# DON'T LET THE CAT OUT OF THE BAG: RECORD KEEPING ISSUES WITH 2SLGBTQIA+ CLIENTS

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# DEDICATION

To those in the 2SLGBTQIA+ community for whom everyday is an act of survivance and resistance. You are seen and valued, and I hope for a kinder future.

To Dr. Dawn McBride, Dr. Blythe Shepard, Dr. Lorraine Beaudin, Dr. Sharon Pelech, and my professors who provided me with more guidance, mentorship, and encouragement than I ever could have dreamed of.

To my cohort, friends, and family who supported me, put up with my incessant frustrations about the state of social injustice, and helped me envision a better world.

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# ABSTRACT

This project critiques the generalist ethico-legal tools and regulations for counselling psychologists in terms of their limited ability to protect the privacy and moral rights of closeted 2SLGBTQIA+ clients. A detailed analysis of extant research, legislation, and ethical guidelines is first presented. To compensate for the limited available literature on this topic, a modified form of the Canadian Psychological Association's (2017a) ethical decision-making model is then applied to a fictionalized case study to indicate the value of an emic, socioculturally contextualized approach to decision-making and recordkeeping. The project concludes with a series of recommendations to mitigate outing risks and enhance the ethicality of recordkeeping outcomes, followed by a draft manuscript to be submitted to a peer-reviewed publication.

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# LIST OF ABBREVIATIONS

***CPA***: Canadian Psychological Association
***CAP***: College of Alberta Psychologists
***GI***: Gender identity
***SO***: Sexual orientation
***TGD***: Transgender and gender diverse
***2SLGBTQIA+***: Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual, plus

# CHAPTER 1: OVERVIEW AND INTRODUCTION

The intent of this project is to depict the necessity of a socially cognizant and culturally responsive approach to counselling psychology record keeping practices. Specifically, I will critique the existing Canadian Psychological Association (2017a) standards for documentation and engage with ethical reasoning through an emic lens to provide recommendations for practice with two-spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual, plus (2SLGBTQIA+) clients, with a particular focus on transgender and gender diverse (TGD) individuals.

This chapter provides an overview of the ethico-legal landscape as it relates to record keeping for counselling psychologists and introduces risks that surface for 2SLGBTQIA+ clients as a result of overdocumentation. Namely, this chapter describes the rationale for the project as well as my interest in this topic. This chapter concludes with a glossary of terms that appear throughout this document and outlines the subsequent structure of this project.

## 1.1 Project Rationale

Record keeping is a compulsory practice that provides a ledger of clinical activities to monitor and justify treatment (Canadian Psychological Association [CPA], 2017a) and promote continuous care (Hodson & McBride, 2022). However, these documents are not privileged communications in Canada (Hadskis, 2018). Psychologists must engage in deliberate efforts to obscure clinical records from outside view (Pope, 2015). Their inability to do so could erode the confidence and well-being of the client, but it could also expose the psychologist to potential professional or legal damages.

Confidentiality is, in fact, a universal right in counselling (CPA, 2017a), but I stipulate that violations in this area via documentation practices may disproportionately affect 2SLGBTQIA+ individuals due to the ubiquity of *cisheterosexism*: the "societal and institutional privileging of heterosexuality, cisgender identity, and binary sex assignment as [a required, desirable, and natural] norm" (The University of North Carolina-Chapel Hill LGBTQ Center, n.d., para. 4). Despite the codification of 2SLGBTQIA+ protections, such as the entry of GI and gender expression into protected grounds (*Act to amend Canadian Human Rights Act and Criminal Code,* 2017), these defenses are "limited, formal" (Calder, 2022, p. 5) and divorced from the oppression that this population is apt to encounter in current society. Given their susceptibility to stigma and discrimination (Nieder et al., 2020), these clients may choose to withhold their gender identity (GI) or sexual orientation (SO), thereby increasing the need to protect their privacy in their clinical records.

Because of this issue, I believe that 2SLGBTQIA+ individuals require additional diligence with respect to the creation and management of session notes, as therapists may inadvertently 'out' these clients by revealing their GI or SO in their files to unknowing 3rd parties (Boroughs et al., 2015), especially if they remain ignorant of the sociopolitical, cultural, and individual circumstances and needs of these individuals. For example, a TGD person may prefer gender expressions that embody their GI in the safety of the therapeutic context. The same individuals may uphold cisgender presentations of the self (e.g., the use of cisgender pronouns and their given name) in other settings, in which case, disclosing their GI constitutes outing. Conversely, some TGD people that 'pass' as cisgender might choose to conceal their GI to avoid social punishment or the invalidation of their identity (Schiffer, 2022). Besides being blatantly disrespectful, misgendering or deadnaming these clients discloses their TGD identity without their consent.

The last example is a form of outing, or "exposing [a 2SLGBTQIA+ individual's SO or GI] to others without their permission" (Human Rights Campaign Foundation, 2023). According to the Community-Based Research Centre (2021), outing can encourage the propagation of cisheterosexist structures, put 2SLGBTQIA+ clients at risk for emotional distress or discrimination, and show disrespect to client's fundamental value and rights of privacy. This source (Community-Based Research Centre, 2021) provides examples of outing interfering with child custody and contributing to physical and psychological violence in the home, incarceration settings, and at the hands of authority figures. Another poignant case is that of Marcus Wayman, who, at just 18 years old, took his own life after police officers threatened to inform his family that he was gay (American Civil Liberties Union of Pennsylvania, 2000). Unfortunately, instances of outing ramifications in health care settings have also been identified. For instance, when noting her fears surrounding clinical documentation, one trans woman interviewed by Thompson (2016) "described how a clinic worker threatened to call the police on her for using the women's restroom when he learned her legal status was 'male" (p. 210). Given this precarity, it is easy to imagine the serious injuries that can arise when documented GI or SO information, shared within the safety of therapy, becomes misappropriated to justify violence by 3rd party viewers. In fact, outing itself is regarded as a type of violence (*AB v CD and EF*, 2019; Ashley, 2019). This substantiates the rejection of GI- or SO-blindness—a presumptuous, one-size-fits-all approach—in the ethical duties of helping professionals.

Despite this, the question of how to protect confidentiality in record keeping remains. There is a paucity of literature and resources addressing this topic for Canadian psychologists (Bradford & Stevens, 2013; Mills, 2014), and there is very little to no guidance regarding charting with 2SLGBTQIA+ clients (Nadler et al., 2021). In fact, despite conducting an exhaustive literature review, I found that no authors have evaluated how 2SLGBTQIA+ people differentially assess typical documentation practices, and none have applied the CPA's ethical decision-making model (2017a) to resolve these conflicts. By ameliorating these gaps, the current project aids in practitioner ethical development and encourages further investigation of means to reduce the threats affecting this growing population (Coleman et al., 2022).

## 1.2 Statement of Interest in the Topic

This project was inspired by my personal experiences with the arduous thought process that most 2SLGBTQIA+ people face in deciding whether to come out to one's health care providers. Upon exploring the lack of privilege in Canadian counsellor-client relationships during an ethics course, I was disheartened to learn about the lack of training in 2SLGBTQIA+ topics and documentation practices in health care educator programs (Coleman et al., 2022; Lau et al., 2020; Nadler et al., 2021).

The recent resurgence of anti-TGD rhetoric and legislation exacerbated these concerns. At the time of creating this project, the American Civil Liberties Union (2023) "was tracking 510 anti-[2SLGBTQIA+] bills in the [USA]". Floridian events depicted a radicalized form of this issue (The Protections of Medical Conscience Act, 2023): Health care practitioners may refuse to treat 2SLGBTQIA+ patients on the basis on personal beliefs, gender-affirming care is restricted for adults and completely banned for all minors (Treatments for Sex Reassignment, 2023).

In fact, just this year, New Brunswick (Mazerolle, 2023) and Saskatchewan introduced “legislation and used the notwithstanding clause to override sections of the Charter of Rights and Freedoms and [their respective] human rights codes” (Simes, 2023), forcing TGD students under 16 years of age to obtain parental consent for the use of gender-congruent pronouns and names. In the case that seeking parental consent may cause harm or conflict with the best interests of the student, the latter will be directed to a counsellor (Simes, 2023), who “will work with the student to develop a plan to speak with their parents *when* they are ready to do so” (Government of Saskatchewan, 2023, p. 4; New Brunswick Department of Education and Early Childhood Development, 2023, p. 4; identical quotations exist in each source). Several key issues are worth noting. In the case that the youth or counsellor deem it inappropriate to seek parental consent, then the former must be referred to by their deadname and pronouns at school and in counselling (Latimer, 2023). A second, deeply concerning insinuation is directly relevant to the scope of this project: Given the fact the student had identified coming out to or seeking consent from their parent(s) as a worrisome or even dangerous endeavour, how do their counsellors manage privacy and confidentiality in their documentation (e.g., when forming a plan to seek consent from parents) when the parents have a legal right to access these records?

As a fledgling in this field, I was extremely concerned about the real threats for my future clients and the perils and loss of power that arise when these decisions, such as documentation of their sessions, are stolen from 2SLGBTQIA+ people. I strongly believed that psychologists need to engage in education and the critical examination of their biases, practices, and the faults of the current landscape in an attempt to supersede their ethical duties and avoid becoming complicit in 2SLGBTQIA+ harm. Hence, I identified a need for this project.

## 1.3 Glossary

***Cisgender***: "People whose current sex and gender identities match the ones they were assigned at birth" (e.g., women who were assigned female at birth and men who were assigned male at birth; Goldman et al., 2020, p. 1085).

***Cisheterosexism****:* The "societal and institutional privileging of heterosexuality, cisgender identity, and binary sex assignment as [a required, desirable, and natural] norm" (The University of North Carolina-Chapel Hill LGBTQ Center, n.d., para. 4).

***Closeted****:* A term referring to a 2SLGBTQIA+ person who has not disclosed their gender identity or sexual orientation (Human Rights Campaign Foundation, 2019). 2SLGBTQIA+ individuals may be closeted in certain environments or with certain people but forthcoming regarding their gender identity or sexual orientation in other places or with other people.

***Gender***: "A person's status as a man or boy, woman or girl, transgender person, nonbinary person, and may also include 2-Spirit persons. Genders are usually assigned at birth on the assumption that people born with male genitals will be boys and that people born with female genitals will be girls" (Goldman et al., 2020, p. 1085).

***Gender identity***: "A person's deeply felt intrinsic sense of their own gender" (Goldman et al., 2020, p. 1085). Gender expression does not always align with gender identity.

***2SLGBTQIA+***: An acronym referring to those who identify as two-spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual, or any other minority sexual orientation, gender identity, or romantic orientation.

***Outing***: "Exposing someone's lesbian, gay, bisexual, transgender, or gender non-binary identity to others without their permission. Outing someone can have serious repercussions on employment, economic stability, personal safety or religious or family situations" (Human Rights Campaign, 2023).

***Privileged communications***: A class of communications that are legally protected from forced disclosure. These communications arise within the context of certain professional relationships (e.g., lawyers and doctors) "where absolute secrecy appears essential to the proper conduct of certain professional functions of great importance to society" (LeBlanc, 1972, p. 11).

***Social gender:*** "The gender in which a person lives their everyday life. A person's social gender may or may not express their gender identity. Similarly, it may or may not match what would typically be expected on the basis of their sex or gender assigned at birth" (Goldman et al., 2020, p. 1085).

***Transgender and gender diverse: "***Members of the many varied communities that exist globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth" (Coleman et al., 2022, p. 55), including transgender, 2-Spirit, and nonbinary individuals.

## 1.4 Chapter Summary and Overview of the Project Structure

This project contains two parts. The purpose of this chapter was to introduce the project topic and structure, including a rationale and statement of interest. To enhance comprehension, this section also included a glossary of terms appearing throughout this document and an outline of its structure. Chapter 2 outlines the methodology for the literature review and ethical reasoning process, as well as a statement of ethical conduct. Next, Chapter 3 presents an analysis of the current ethico-legal standards for Canadian counselling psychologists as well as a detailed review of the literature pertaining to record keeping, ethical decision-making, and the specific needs of 2SLGBTQIA+ clients. In Chapter 4, I will describe a fictional vignette containing a moral dilemma pertaining to the issue of outing TGD clients through counselling documentation. I will then introduce and apply a modified form of the CPA's (2017a) ethical decision-making framework — developed based on the findings from the literature review—to a fictional dilemma. Recommendations for charting with 2SLGBTQIA+ counselling clients are provided in Chapter 5. Chapter 6 addresses the implications of this project, including practical recommendation for charting counselling sessions with 2SLGBTQIA+ clients. It also presents the strengths and limitations of this project and potential areas for future research. The seventh and final chapter constitutes the second portion of my project. It includes a manuscript (Appendix 1), co-authored with my supervisor and adapted from Part 1, to be submitted for publication as an independent document. The manuscript will contain a fictional case study that resolves ethical issues related to psychological notetaking for a 2SLGBTQIA+ client as well as broad recommendations to aid practitioners in this task.

# CHAPTER 2: METHODOLOGY

The intent of Chapter 2 is to describe the methodology used to obtain the literature used to inform this project. To commence this chapter, I will describe the search process, terms, and databases used during the literature review. Concluding this chapter will be a statement of ethical conduct and a summary outlining its contents.

## 2.1 Research Process

This project's literature review was informed by publications surrounding the ethico-legal premises of psychological record-keeping for 2SLGBTQIA+ clients. Because the literature relevant to the topic of this project is scant, I implemented a more inclusive search to incorporate research on general confidentiality challenges in record-keeping and those pertaining to stigmatized characteristics in general. An array of search terms was thus used both individually and in tandem to accrue relevant research: psychology*, counsel*, therap*, health, records, file, document*, chart*, notes, LGBT*, trans*, gender, nonbinary, queer, stigma, decision-making, out*, closet*, confidential, priva*, privilege, ethics, and regulations. The following databases were used to extract relevant items from the corpus of existing research: Google Scholar, JSTOR, PubMed, CanLII, Web of Science. The keywords were also applied to search the University of Lethbridge library. The items used primarily consisted of scholarly, peer reviewed articles. However, given the need to address the regulations guiding clinical practice and the paucity of research on this project's topic, resources from clinical and legal authors were also used. The date range for the search was truncated to between the years of 2017 to 2023 for articles specifically related to *the Canadian Code of Ethics for Psychologists* (hereby referred to as *the Code;* CPA, 2017a) and those surrounding psychological practice with 2SLGBTQIA+ clients in the Canadian literature. This period was chosen to reflect the professional climate in the year of publication for the most recent version of *the Code* (CPA, 2017a) and the year in which GI and gender expression became enshrined into protected grounds under constitutional law (*An Act to amend the Canadian Human Rights Act and the Criminal Code*, 2017). Because of the paucity of research on this topic, the aforementioned search terms were also applied to Google to recruit further scholarly resources, which were then accessed through the databases described above. Finally, reviewing the materials referenced in the literature already collected also served as means to identify relevant works. This search process evolved over 10 months.

## 2.2 Statement of Ethical Conduct and Code of Ethics Used

At all times during the construction of this project, I adhered to the *Canadian Code of Ethics for Psychologists* (CPA, 2017a), the *Guidelines for Psychological Practice with Sexual Minority Persons* (American Psychological Association [APA], 2021), and the standards communicated in the *Publication Manual of the American Psychological Association* (APA, 2020). There was no research conducted on human participants; thus, I did not seek approval from the research ethics board.

## 2.3 Positionality Statement

To enact the essence of this project's praxis, a brief discussion of the author positionality is in order. Primarily, it should be noted that I am a queer, cisgender woman of colour. Despite having observed the adversity faced by TGD individuals in my personal life and in the public domain, my own experiences are notably devoid of first-hand cissexism. This identity deploys subjective epistemological conditions, and thus, the interpretations posed in this work are merely that: interpretations that interlay with my social location.

Moreover, I believe it is challenging if not impossible to fully assume another lived perspective for which I do not have first-hand experience. For this reason, the exemplar analysis found in Chapter 4 consists of a recursive introspective process grounded in my own social location. However, it should be noted that this case study is fictional and purely reminiscent of my positionality; it is derived from but does not completely capture my views.

## 2.4 Chapter Summary

The goal for Chapter 2 was to provide an overview of the methods used for the literature review of this project. However, albeit unintentional, the chapter also highlighted the deficit of resources for counselling psychologists navigating ethical privacy and confidentiality dilemmas for closeted 2SLGBTQIA+ clients, thereby reaffirming the need for this project. In Chapter 3, an analysis of the literature surrounding ethico-legal guidelines and charting concerns will be provided, with a particular focus on evidencing the need for an emic approach to decision-making for issues of this kind. The chapter closes with a discussion of supplemental resources that may be used to achieve this approach, which serves to prime for the analysis of the fictional case study in the subsequent chapter, Chapter 4.

# CHAPTER 3: LITERATURE REVIEW

Violations of privacy committed by psychologists during documentation need not be intentional or malicious in intent to provoke egregious effects, but, given their potential for harm, the detriment of these experiences cannot be overstated. Given their fiduciary role, in every instance of creating session notes, “nothing can spare [counsellors] the responsibility of asking: What format and content best fit this unique patient and the current therapeutic situation?” (Pope, 2015, p. 353). Unfortunately, there is currently little guidance to help Canadian counselling psychologists answer these queries. Therefore, it is my intention to offer some considerations so Pope’s questions can be addressed, particularly as they relate to 2SLGBTQIA+ clients.

In this chapter, I will introduce charting standards for Canadian counselling psychologists as well as an overview of pertinent literature on general record keeping issues. Although a full examination of regulations is beyond the scope of this review, an essential section in this chapter will highlight relevant professional expectations, principles in *the Code* (CPA, 2017a), and laws. Whenever possible, I will link this review to issues distinctly affecting 2SLGBTQIA+ individuals in order to present suggestions for actualizing ethical conduct with this clientele. To begin, a review of the standards of practice for Canadian counselling psychologists will be presented.

## 3.1 Professional Standards

### 3.1.1 Moral Conduct

In Alberta, psychologists and researchers in the field of psychology adhere to *the Code* (CPA, 2017a) to guide professional morality. The CPA (2017a) described the organization of this framework as premised upon ideal conduct: Principles represent ranked aspirational goals that function as broad categories for values and standards. Following this, values are subsets of principles that clarify the definition of the parent category. Each provincial regulatory College interprets *the Code* into standards, the smallest subset of directives, which communicate minimum behavioural rules and provide examples for the enactment of the values and principles in which each is contained. Compliance with these rules is imperative for the field of counselling psychology to enjoy self-governance (CPA, 2017a), and the *Code* makes explicit reference to this obligation. Several intentions were present in the formation of this document (CPA, 2017a): to provide a generalist model establishing basic enforceable professional regulations across the entire field of psychology, to aid "in the adjudication of complaints against psychologists" (p. 6), and to direct regulated members' moral conduct and reasoning according to CPA philosophies.

### 3.1.2 Charting

*The Code* (CPA, 2017a) includes charting standards that exist to ensure the protection of clients. These guidelines communicate moral obligations in all aspects of record management, while failures in this area may induce serious ramifications, including licensing restrictions, expulsion from the profession, or legal action. Namely, recordkeeping practices must strive to meet all four principles (CPA, 2017a; Korkut & Sinclair, 2020; CPA, 2017b): I) Respect for the Dignity of Persons and Peoples, II) Responsible Caring, III) Integrity in Relationships, and IV) Responsibility to Society. This chapter will allude to these principles to highlight the care and respect required in documentation practices with 2SLGBTQIA+ clients.

### 3.1.3 Confidentiality in Record keeping and the Fiduciary Relationship

### ***Privacy and Confidentiality***

The psychology field recognizes that counselling outcomes are contingent on privacy and confidentiality. The CPA (2017a) specifies that personal information must be collected and managed "in a way that attends to the needs for privacy, confidentiality, and security" (I.41). This limits the details collected to only those legally required (e.g., to manage risks) or germane to and supportive of "continuous, coordinated or collaborative service" (p 16). These moral rights have been codified by regulatory bodies to become intertextual with legal regulations. Specifically, ethico-legal entities dictate the parameters of confidentiality insofar as "balancing the public's right to know [with] the individual's right to privacy" (Government of Alberta, 2023, para. 2). Compliance with both national and regional regulations and legislation is compulsory for Canadian psychologists. For this reason, Albertan psychologists who are members of the CPA are subject to the privacy and confidentiality safeguards enshrined into *the Code* (CPA, 2017a), provincial (e.g., *Personal Information Protection Act* [PIPA; College of Alberta Psychologists (CAP), 2019], and federal privacy laws (e.g., *Personal Information Protection and Electronic Documents Act* [PIPEDA]), as well as CAP's *Standards of Practice* [2022]).

### ***The Fiduciary Relationship***

The aforementioned standards and regulations correspond to the fiduciary status of the therapeutic alliance, that is, a relationship that is based on trust. In the decision of *McInerney v MacDonald* (1992), Justice Gérard V. La Forest highlighted the fiduciary duty "to hold information received from or about a [client] in confidence" (para. 2). Echoing these sentiments in the Supreme Court decision on *R v Mills* (1999), Justice Claire

L’Heureux-Dubé explicated the vital role of confidentiality in the development of trust, ultimately arguing that upholding the client’s “reasonable expectation of privacy in [their] therapeutic records protects the therapeutic relationship” (para. 5). This is of special importance for 2SLGBTQIA+ individuals given the commonality of their experiences with microaggressions, misgendering, mistreatment, and service failures stemming from healthcare providers as a whole (Coleman et al., 2022; Lau et al., 2020).

It is understandable why 2SLGBTQIA+ individuals would be hesitant to come out to their provider in this context. The effects of this concealment have yet to be studied but based on research highlighting inadequacies in care arising from inadequate GI or SO capturing processes in health care records systems (Hurren et al., 2023), it seems that for 2SLGBTQIA+ individuals, withholding GI or SO from their provider may contribute to gaps in their care. This signals the importance of providing 2SLGBTQIA+ clients with a trustworthy therapeutic relationship and conditions that allows them to safely disclose their GI or SO to their counsellor.

In relation to this project, honouring fiduciary trust entails respecting 2SLGBTQIA+ clients’ right to come out at their own volution. Throughout this project is reference to consent—that is, the need for counselling psychologists to take great care in informing clients of their limits to privacy—and to compensate for circumstances wherein they may be unable to fully protect their privacy and confidentiality. For instance, with 2SLGBTQIA+ clients accessing EAP services, therapists must remain cognizant that any number of unidentified staff, insurance representatives, or other 3rd parties may access their session notes. In this context, the question then becomes: How can the therapist offer loyalty and protection when there is no privilege for Canadian therapists, and they are required to document potentially outing information by the very systems and regulations intended to protect and benefit the client?

#### ***Ownership***

This issue is also subject to the influence of case laws clarifying proprietorship. For example, the decision of *McInerney v MacDonald* (1992) implies that the physical documents in client records belong to the psychologists responsible for their production, but because session notes contain the client's personal health information, clients appear to be the proprietors of this content. This stance on ownership may create opportunities for clients and 3rd parties, who may be unaware of the client's GI or SO, to access information recorded in the former's psychological records.

#### ***Access***

Generally, clients can exercise their right to access and share their records at their discretion (*McInerney v MacDonald*, 1992), and the only exceptions to this right are circumscribed: a foreseeable, significant risk of harm to the client or another specific party as a consequence of permitting or refusing access (CPA, 2017a). A willingness to comply with client requests for access may enhance the ethical characteristics of the fiduciary relationship, namely, the encouragement of equal power and trust. Thus, a therapist that provides 2SLGBTQIA+ clients with access to their files and informs them of the implications of these actions before doing so aligns with both legal mandates and best ethical practice.

## 3.2 Barriers to Maintaining Confidential Records

### 3.2.1 Lack of Privilege

As previously noted, psychological records are not privileged under Canadian law (Hadskis, 2018). However, I align with the position that "if something is truly confidential, it is not subject to review by anyone else without the patient's or psychologist's permission" (Mills, 2014, p. 102), because "[clients] release personal information in the context of the [therapeutic] relationship with the legitimate expectation that [their confidentiality] will be respected" (*McInerney v MacDonald*, 1992, para. 2). Unfortunately, the possibility of a confidentiality breach may disintegrate clients' trust in the therapeutic relationship and any future help-seeking efforts (*R v Mills*, 1999).

These issues might suggest that therapists should avoid documenting information with potentially injurious consequences for clients (Bradford & Stevens, 2013) to manage confidentiality threats, but this strategy may "have interesting implications for . . . issues [and identities] that are stigmatised by the community, and sometimes even within the profession" (p. 179). For example, what does one do if their agency requires them to specify the name of the relationship for the client's same-gender partner that serves as their emergency contact? Also, how can psychologists ensure that agency staff use the correct names and pronouns for a client that prefers this, but who does not want this information recorded in their file?

These examples pose ethical quandaries for the therapists committed to protecting their clients and the latter's moral rights. In the next section, I will outline two common risks to client privacy with the aim of elucidating their particular perils for closeted individuals.

### *3rd Party Access*

The decision of *McInerney v MacDonald* (1992) cited the growing phenomenon of 3rd party access. Despite numerous levels of privacy protections, disseminating clients' personal information to governmental agencies, 3rd party payers (e.g., insurance companies), guardians, researchers, and other outsiders is often granted. For instance, the *Code*'s standards (CPA, 2017a) identify collaborative, continuous, and coordinated care as justifications for the collection and dissemination of client data, which insinuates that other providers within one's circle of care may be privy to this information (*Health Information Act*, 2000). To satisfy judicial processes, session notes may also be subpoenaed for the review of legal professionals, but if produced in court, these documents may then become available to the general public as court proceedings are open to the populace at large.

The ethical concerns for confidential records for 2SLGBTQIA+ clients mirror those of the complainant in *R v Carosella* (1997). Clients susceptible to stigma or other socially situated threats (e.g., closeted 2SLGBTQIA+ clients or victims of sexual assault) may suffer harm as a stemming from 3rd party knowledge of their personal information (Chivilgina et al., 2022; Coleman et al., 2022). Unfortunately, the identification of same-sex partners, descriptions of gender dysphoria, and even minutiae like names and pronouns can out the client if recorded in session notes, whereupon they may face stigmatizing or blatantly discriminatory behaviours from those privy to this personal information. Like with all instances of 3rd party disclosure (CPA, 2017a), GI or SO information can also be misinterpreted by those outside the therapeutic alliance. Therefore, being outed at the hands of clinicians can have detrimental consequences and is regarded by some as a form of violence (Drescher & Fadus, 2020).

### ***Minors***

Clients under the age of majority seem to be especially susceptible to confidentiality threats, as standards and regulations seem to recognize access to minors' personal information as a necessary trade-off for their support and protection. For example, the *Health Information Act* (2000) and the case of *SDK v Alberta (Director of Child Welfare* (2002) suggest that the guardians of young clients are entitled to access the information about them or their children when this data exists in the records of public service providers. Additionally, the former permits disclosure to public health clinicians for the purposes of wrap-around and continuous care, while Alberta's Children First Act (2013) extends the criteria for eligible recipients to include personnel in police service, governmental departments, educational bodies, and any "organization that provides programs or services for children under an agreement with a public body" (para. 1). There might also be a risk of expanding the potential applications of the Children First Act, which could further increase its already-vast inclusion criteria identifying eligible recipients of personal health information (McBride, 2022). This has serious implications for those who are entering counselling to begin to explore their GI or SO but who do not wish to share these contemplations with those outside the therapeutic space.

In all these cases, sharing records must rest upon a good faith assumption that doing so is in the best interests of the client and will not result in significant harm to any person (Children First Act, 2013; Health Information Act, 2000; *SDK v Alberta (Director of Child Welfare*, 2002), but in doing so, providers may inadvertently violate the client's moral rights or contribute to adverse consequences. Thus, it seems that psychologists require the development of ethical proficiencies to assist them in balancing the need for disclosure with that of confidentiality in protecting all clients' well-being. Hence the value of this project.

### 3.2.2 Lack of Research

The paucity of research is an obstacle to the remediation of this record keeping concern. Though legal and ethical scholars have commented on this issue (e.g., Bemister & Dobson, 2011; Pope, 2015; *R v Mills*, 1999), no Canadian empirical studies could be located that investigated therapists' views surrounding the conflicting demands of confidentiality protections and the clinical need for detailed client information. The lack of Canadian research on therapists' views on confidentiality versus detailed client information is concerning. Without such data, difficulties in balancing client privacy and clinical requirements arise. Likewise, there is a noticeable paucity in literature on charting practices that are tailored to the needs of 2SLGBTQIA+ clients in Canadian counselling psychology. This gap must be addressed to ensure that all clients receive the best possible care, regardless of their SO or GI.

### 3.2.3 Lack of Training

#### *Documentation*

The void of literature above mirrors a seemingly universal knowledge gap contributing to therapists' confusion: With regard to charting personal information, how much detail is too much? McBride (2010) offered several recommendations as it relates to documentation with clients with a background in trauma. More recently, Chivilgina et al.'s (2022) thematic analysis of Swiss psychiatrist survey data (n = 20) reported that their sample was divided in terms of the amount of detail to be provided in session notes, with some of their participants arguing for the inclusion of more information, and others advocating for less. The participants in Kilty and Orsini's study (2019) also identified challenges in trying to balance confidentiality, client trust, and the dissemination of client information, or "the medical benefits of knowing, and the ethical pitfalls of sharing, related to stigmatization" (Chivilgina et al., 2022, p. 9). This also represents the crux of privacy legislation (e.g., FOIP; Government of Alberta, 2023). Given the disclosure-confidentiality dilemma across the field, it seems probable that current clinicians are unprepared for complex or high-risk situations like stigma and closeted GI or SO in their documentation practices.

#### *2SLGBTQIA+-Specific Ethics of Care*

Several studies have also indicated deficiencies in training and competence for practice with 2SLGBTQIA+ clients, especially those who are TGD, across healthcare professions (Baiocco et al., 2022; Coleman et al., 2022; Lau et al., 2020; Schreiber et al., 2021). Indeed, a recent literature review revealed reports from TGD patients wherein their gender information "was involuntarily disclosed, misinterpreted or abused, and their safety and care [were] compromised" (Lau et al., 2020, p. 1779). These effects have also been documented in healthcare settings (Coleman et al., 2022), with fears of staff mistreatment and outing exacerbating the already significant underutilization of healthcare services among this demographic. Given this context, it is unsurprising that—due to fears of being outed—the counselling relationship, foundational therapeutic skills, and confidentiality seem to be the most significant factors in 2SLGBTQIA+ clients' appraisals of counselling (Israel et al., 2008).

### 3.2.4 Provider Fears

Like clients, therapists likely also hold concerns over the surveillance of clinical records and a potentially litigious landscape, which contributes to an anxious professional climate oriented towards self-protection (Mela et al., 2016). These fears might encourage the use of "defensive record keeping” (Pope, 2015, p. 354), which focuses on rigid, rule-based, reactive morality and risk management to avoid punishment from professional or legal entities. Resorting to these tactics may thus encroach on the ethical duty to prioritize the rights and interests of clients above those of any other person, including therapists themselves (Zur, n.d.), during record keeping. The following section will outline some suggestions for actualizing an aspirational charting approach to surmount ineffective fear-based methods.

## 3.3 Striving for Ethical Documentation

In surmounting charting issues through the application of ethical frameworks, the intentional use of fortitude, creativity, and analytic decision-making skills seems to be pivotal, especially in the case of conflicts that are exceptionally difficult to resolve. Despite this, deciphering methodology for translating these abstract attributes into real clinical practice is less clear. As already noted, it is not advisable to approach ethics through the lens of rule-based thinking (Barstow, 2021; Pope, 2015). Rather, it is with a deep familiarity with ethical aims and the adoption of equitable interpersonal conduct through which psychologists may foster beneficial relationships with clients to co-construct ethical uses of power.

Being a “neutral concept, it is how power is used that makes it either harmful or benevolent” (Barstow, 2021, Definitions section). These premises are embodied in the notion of right use of power, a concept coined by Barstow that requires one to “be informed, compassionate, connected, and skillful" (2021, Definitions section) in the use of influence and power "to prevent, reduce, resolve, and repair harm". This aspirational approach can be used in lieu of reductionist, mechanistic views of ethical conduct. When creating session notes, for instance, psychologists might consider that their fear-based, punishment-avoidant approach to ethics may exacerbate the risks of misusing power in such a manner that the psychological records become more focused on protecting counsellors—who already hold the most power in therapeutic alliances—instead of clients. The basis of this approach lacks compassion, cognizance of power, and a relational etiology. Instead, psychologists may consider that drawing from their connection with the client in charting and decision-making may help them maintain compassion and dedication to the latter's interests while reducing the pressure associated with making autonomous choices, thus enhancing the ethicality of their conduct according to *the Code's* (CPA, 2017a) principles.

### 3.4 Navigating Record Keeping Dilemmas

The concerns described throughout this chapter elucidate the necessity of ethical decision-making measures surrounding the documentation of TGD clients' case information. To begin, an introduction to *the Code's* ethical decision-making tools (CPA, 2017a) will be shared to contextualize the discussion. The remaining part of the chapter will provide an overview of relevant ethical resources corresponding to the fictional case study to be presented in Chapter 4. This information will provide a rationale for the value of an emic, critical ethics analysis for documentation outing risks through the use of reflexivity, co-leadership, and relational uses of power. It is hoped this section will provoke the reader to uncover cisheterosexist assumptions embedded into regulations, professional philosophies, and personal perspectives often taken for granted.

### 3.4.1 An Overview of the CPA's Ethical Decision-Making Tools

*The Code* provides multiple resources to aid in moral decisions (CPA, 2017a, 2017b), including weighted principles, space for personal conscience, and an ethical decision-making model. The first is a rather unique feature whose sequence of presentation within *the Code* (CPA, 2017a, 2017b; Korkut & Sinclair, 2020) reflects their order of priority. However, all demand consideration, and their weighting may vary according to the demands of the situation at-hand. When the complexities of moral dilemmas supersede the capacity of *the Code's* guidelines, the counsellor may choose to employ its ethical decision-making model to aid in a robust, reflexive, and intentional analysis (CPA, 2017a).

### 3.4.2 Upholding the Code When Charting for Closeted Clients

The following section will introduce *the Code's* (CPA, 2017a) four principles with respect to their ability to protect privacy and confidentiality for 2SLGBTQIA+ clients. The purpose of this overview is to offer interpretations of each principle and the ethical decision-making model as they apply to recordkeeping with closeted clients.

#### *Principle I: Respect for the Dignity of Persons and Peoples*

This principle is the most imperative and consequently holds the most weight (CPA, 2017a). The successful enactment of this goal is predicated on one's ability to demonstrate deep respect for the fundamental rights and freedoms of all people in record keeping and all other duties. Practices must uphold and promote essential human worth, non-discrimination, "moral rights, and distributive, social, and natural justice" (CPA, 2017a, p. 11). Attending to the autonomy and dignity of clients respects their personal power (Barstow, 2021), while the weighting of this principle implies that these elements are *sine qua non* for ethical practice. With respect to documentation of 2SLGBTQIA+ clients, this might include any of the following: providing a consent process that ensures clients are aware of their rights and limits to the privacy (e.g., ensuring clients know it is their right NOT to indicate their pronouns [GI-congruent or those assigned at birth]); informing clients prior to the completion of any registration paperwork that there are limits to their privacy (e.g., describing to whom their file and identified pronouns would be accessible); maintaining absolute privacy and confidentiality where possible, utilizing validating and respectful language, deferring to clients as the primary authority in the transcription of and access to their information (CPA, 2017a), updating their name and pronouns as often as they desire (Potter, 2020), using terms reflecting their authentic GI (Coleman et al., 2022), or recording only the GI- or SO-related terminology permitted by the client.

The *Code* (CPA, 2017a) also acknowledges that sociocultural identities interact with personal characteristics to form subjective perceptions and constructions of meaning, and it is unequivocal in mandating universal respect for human diversity. Notably, complying with these directives demands the comprehension and consideration of social structures, including their potential infringements on human and moral rights. This is premised upon the fact that individual and community characteristics determine the extent of protection of moral rights needed. For example, the most vulnerable stakeholders are owed the greatest responsibility from the CPA's (2017a) regulated members. Thus, when charting 2SLGBTQIA+ clients' sessions, it would be wise to utilize inclusive and affirming language (Potter, 2020), co-create records with clients to increase their self-determination and social power, acknowledge that privacy is subjective between groups and individuals (CPA, 2017a), and modify the use of terminology and the level of detail in recorded content to reflect the client's desire or lack thereof to come out.

### *Principle II: Responsible Caring*

The essence of Principle II is a genuine concern for the well-being and best interests of all people that psychologists contact (CPA, 2017a). The CPA's regulated members must take active steps to increase beneficence and reduce malfeasance while simultaneously supporting each person's right to protect their own interests and make their own decisions. Additionally, this directive establishes the value of informed consent. *The Code* (CPA, 2017a) also describes exceptions to moral rights to be identified during consent negotiations, such as limits to confidentiality where there is a significant concern for safety. For record keeping with 2SLGBTQIA+ clients, this may entail significant care in explaining the risks and benefits of the therapist's notetaking style, "avoiding the use of potentially triggering terms" (Potter, 2020, p. 54), or methodically determining an approach to record keeping that adequately benefits the client and resists the potential risks of outing.

Finally, competence is identified as a requisite for this principle, and like Principle I, Responsible Caring (CPA, 2017a) indicates that members' greatest responsibility is for those who are the most vulnerable. This principle requires all clinicians, but especially those with 2SLGBTQIA+ individuals on their caseload, to ensure their documentation practices showcase care and concern for the limits to privacy clients have in Canada. Furthermore, each psychologist must participate in ongoing, evidenced-based training on relevant theoretical and practical knowledge, including "best practices for assessment, support, and treatment approaches with [2SLGBTQIA+ individuals]" (Coleman et al., 2022, p. 571), as well as the ethical needs of this group—a duty that includes record keeping professional development. Continuing education should also develop knowledge on diversity, power, and sociocultural influences (e.g., marginalization and historical events contributing to oppression) in addition to the explication and remediation of cisheterosexist biases in striving for 2SLGBTQIA+ cultural competence (Baiocco et al., 2022; Potter, 2020) and rights (Coleman et al., 2022). Psychologists lacking in this area may be susceptible to misinterpreting presenting problems or the significance of factors (e.g., safety) as they relate to 2SLGBTQIA+ identity (Coleman et al., 2022), thereby obfuscating the use of effective and affirming language recorded in the client's file.

### *Principle III: Integrity in Relationships*

This principle underscores the importance of constructing relationships characterized by confidence and mutual integrity. Its values parallel the attributes necessary for achieving these goals: accuracy and honesty, straightforwardness and openness, maximization of objectivity and minimization of bias, avoidance of conflicts of interest, and extended responsibility (CPA, 2017a). For example, in charting with their 2SLGBTQIA+ clients, counsellors may strive for the accuracy of session notes or the use of open session to enhance transparency (CPA, 2017a; Hodson & McBride, 2022).

Furthermore, the CPA (2017a) requires psychologists to utilize careful, deliberative processes (e.g., ethical decision-making) to achieve objectivity in their judgements, such as those surrounding the charting of sessions. The standards state that at all times, counsellors must strive to limit their biases, be honest with regard to their competence, and provide a degree of information sufficient for stakeholders to make their own decisions. Example practices may include clearly identifying possible circumstances permitting 3rd party access to documented GI or SO information and utilizing training, supervision, consultation, and reflexivity to reduce cisheterosexist biases. Thus, these strategies may represent means to potentially increase integrity in charting practices with 2SLGBTQIA+ clients.

#### ***Principle IV: Responsibility to Society***

Psychologists must uphold their responsibilities to the society in which the discipline exists (CPA, 2017a). Members are accountable to society. As such, they are expected to both increase the knowledge base of the profession and actively benefit the population as a whole. Professional activities must also respect the value of societal customs, history, policies, and structures. Nonetheless, if structures and policies contravene with the principles outlined in *the Code*, then psychologists have a duty to highlight and remediate these errors, ideally via consensus or democratic means.

In summary, it is incumbent on counsellors, when charting, to uphold and promote the rights of the 2SLGBTQIA+ community in accordance with the principles of the *Code* (CPA, 2017a), even when features of the profession contraindicate these moral rights. Similarly, the next section will describe the biases embedded into these frameworks as well as additionally aspirational guidelines to prime for the analysis of the dilemma presented in Chapter 4.

### 3.4.3 Benefits of the CPA's Ethical Tools

### *Facilitation of Decision-Making Skills*

Johnson and colleagues (2022) contended that "improved decision quality, acceptability of model use, and preparedness for difficult situations" (p. 202) constitute some of the evidenced benefits for ethical decision-making models in general. The structured, cognitive basis of the CPA's model might support ease of use for resolving an array of novel matters (Antes et al., 2009). Novice practitioners, in particular, may benefit from these attributes, which appear to enhance comprehension of decision-making duties and the development of relevant rational and fundamental skills (Antes et al., 2009; Seymour et al., 2004). Indeed, Williams et al. (2012) found that, when provided with the structure offered by the CPA's ranked order principles (2017a) during ethical training, students made quicker moral decisions that were congruent with *the Code*. The structure of its tools may be sufficient to reassure the confidence of providers (Ward, 2017) and field their attention both to present problems and the prevention of similar issues in the future.

### *Wide Applicability*

*The Code's* generalist foundations may render decisions applicable to pluralities of psychological subdisciplines (CPA, 2017a, 2017b; Johnson et al., 2022). In accommodating this vast scope, it makes concessions in the rigidity of its structure. For example, *the Code* notes that "definitions of what is considered private vary" (CPA, 2017a, p. 11), and clinicians are permitted to reweigh each category according to the demands of the situation. Implementing this modification, reflexivity and the resolution of biases (CPA, 2017a) appears to have higher importance for issues involving diverse individuals because societal prejudice often seeps into institutions and clinical reasoning

(Korkut & Sinclair, 2020). The complexities of social problems, such as outing and cisheterosexism, may also justify supplementing the CPA's decision-making model with applicable resources (Pettifor, 2001; Ward, 2017). For these reasons, *the Code* (CPA, 2017a) and its framework are viewed as "less narrow in their prescriptions" (Williams, 2004, p. 30) and accommodating to subjectivity and context.

### 3.4.4 Limitations of the CPA's Ethical Tools

#### ***Limited Literature***

Much of the limited research on *the Code* (CPA, 2017a) appears to focus on the feature of weighted principles, and despite conducting a thorough sweep of the literature, virtually no studies specific to the CPA's (2017a) ethical decision-making framework could be located. The empirical research on ethical decision-making models in general is sparse (Johnson et al., 2022), and therefore many of the proposed benefits of the CPA's model are theoretical or inferred from generalist literature.

#### ***Philosophical Orientation***

Like Canadian legislation (Herriot & Knight, 2023), *the Code* (CPA, 2017a) has been criticized as having been produced by and for the privileged, such as psychologists as well as straight and cisgender individuals (Clark, 2012; Ward, 2017) and thus communicates their values and power structures. This includes Liberal, Euro Western colonial epistemologies surrounding individualism, objectivity, rationality, and hierarchical power (Clark, 2012; Fellner et al., 2020; Goldenberg, 2015; Walsh 2015; Ward, 2017). These philosophies have been championed, normalized, and therefore masked within the field, so much so that they have become considered the only valid form of reasoning in psychology (Ward, 2017). Though corresponding with the views of psychologists (Seitz & O'Neill, 1996), the CPA's ethical priorities may misalign with those of the public, who, for instance, selected Principle III, Integrity in Relationships, as their prime concern in Gothjelpsen and Truscott's study (2018).

### ***Power and Social Justice***

*The Code* (2017a) might also be seen as having a blasé attitude toward rectifying social inequities, according to the stance of some critics. Social justice seems to be most prevalent in responsibility to society, the lowest ranked principle in the CPA's weighting, but, as Goldenberg (2015) and Ward (2017) argued, is seemingly at odds with its positivist ideology. The two authors (2015; 2017) argued that worse yet is the prospect that critical inquiry and social justice become rejected or even used to protect the systems of hegemonic power within the profession (e.g., maintaining hierarchy or preventing allegations of negligence) rather than genuine equity-seeking efforts. CPA (2017a) members are directed to respect societal structures, in spite of their extant issues, leaving social justice issues largely relegated to the efforts of community, critical, and feminist psychologists (Pettifor, 2001). Thus, it may be assumed that for the average therapist, remediating or even fully articulating the impacts of cisheterosexism is not strictly required yet misses the value associated with the adoption of these priorities.

### ***Limited Attention to Context and Subjectivity***

It is also possible that *the Code's* (CPA, 2017a) inclination towards objective and quotidian ideologies might also foster reductionism (du Preez & Goedeke, 2013; Goldenberg, 2015; Walsh, 2015; Ward, 2017) to the factors of subjectivity, diversity, and context (Teo, 2009, 2010, 2015)—necessary considerations for the pluralistic Canadian climate. Its guidelines may be too vague and far-reaching to effectively address issues specific to 2SLGBTQIA+ people. Albeit facilitative for cognitive processes (Antes et al., 2009), this emphasis may also misalign with real-world decision-making experiences. Instead, some scholars have posited a social constructivist and phenomenological view of ethical decision-making that is rooted in dialogue and heavily influenced by subjectivity (Goldenberg, 2015; Levitt et al., 2015; Walsh, 2015).

### ***Autonomous Reasoning***

According to *the Code*, (CPA, 2017a) consultation is “encouraged and expected... when appropriate” (p. 5) but not mandatory, and there is no suggestion at all to consult with clients. However, I argue that maximizing client participation throughout analysis is both essential and congruent with the animus of *the Code* (CPA, 2017a; Goldenberg, 2015; McBride, 2022) when the circumstances entail diversity, marginalization, or safety concerns like outing (Young & Kenny, 2022). In these cases, a lack of understanding or competence may produce unethical or even unsafe outcomes for 2SLGBTQIA+ clientele.

There is also the possibility that characterless, stereotypical, or detached conceptualizations of 2SLGBTQIA+ individuals may arise due to autonomous reasoning. From a Heideggerian lens, through the use of words, perspectives of objects or people “may become hardened so that we can no longer grasp [their character and true essence]” (Heidegger, 2000, p. 61). Client attributes and needs cannot be predicted through professional training or previous experience in practicing with 2SLGBTQIA+ individuals, and without exploring these facets during sessions, pivotal factors and tensions may become obscured, thereby potentially endangering the client by fostering cultural incompetence.

In addition, autonomous ethical decision-making may also reinforce hierarchical power in the alliance: top-down decision-making embodying ‘doctor knows best’ (Barstow, 2021; Goldenberg, 2015; Ward, 2017). Because 2SLGQBTQIA+ clients are already robbed of power in general society, they require greater care in restoring equity in the alliance (Young & Kenny, 2022), but these gains may be nullified by working without their participation of even consent. The absence of interpersonal contact in decision-making may thus contribute to fragmented reasoning devoid of richness and nuance by removing 2SLGBTQIA+ individuals from their humanity, context, and power.

### 3.4.5 Supplemental Sources of Information

#### *Intrapersonal*

Despite their utility, ethical decision-making tools cannot ensure competence nor ethicality (Pettifor, 2001). Psychologists bear these responsibilities (Ward, 2017). They exist in subjective silos when making decisions with complexities superseding the capacities of these tools, and thus they are “ultimately alone in their moral choices” and in facing their consequences (Austin et al., 2005, p. 203). When unchecked, intrapersonal biases and experiences may moderate self-awareness and consequently the actual enactment of the chosen course of action (Rogerson et al., 2011; Walsh, 2015), and they may contribute to overestimating ethicality. Furthermore, maintaining an awareness of intra- and interpersonal forces may facilitate a fulsome understanding of their effect on reasoning (Hill et al., 1998; Korkut & Sinclair, 2020). Thus, it is worth begging the question: What subjective forces shroud their thinking during choice formation and analysis?

#### *Interpersonal*

Particularly for novel or stigmatized issues or those involving equity-seeking groups, external auditing may ameliorate the impacts of bias and lack of knowledge. Seeking training, supervision, or profession consultation are recommended mediums for areas of clinical incompetence (CPA, 2017a, 2017b). Furthermore, both introspection and interpersonal contact enhance cognitive processes, “empathic concern, and perspective-taking (Conway & Gawronski, 2013, p. 216). For example, the seemingly common occurrence of unsubstantiated overemphasis on TGD GIs (Nieder et al., 2020) may be tempered through client consultation and deference to their perspectives. Possibly the most important benefit of client consultation for notetaking, however, is the fortification of discernment by expounding essential considerations (e.g., to whom they are closeted, if their safety is compromised by cisheterosexism, and whether this calls for the reweighting of principles) and capitalizing on this information for the co-development of a functional charting approach.

The imbalanced power inherent to counselling relationships (i.e., the power differential) underlies the necessity of ethical codes of conduct (CPA, 2017a, 2017b; Zur, n.d.) but poses additional considerations for decision-making. According to Barstow (2021) “power is relational” (Definitions section) and represents the foremost vehicle for ethics. The author, in fact, argued that “challenging systemic power successfully can only be done with collective power. It cannot be done alone” (Systemic Power section). Given these qualities, client consultation may provide an opportunity for the right use of power by increasing that equity-seeking client and promoting integrity within the alliance—outcomes embodying the spirit of the CPA’s principles (2017a)—whilst alleviating pressure from psychologists to make high-stakes decisions on their own. Thus, therapists would be wise to question how they want to use their power—over the client or with and for the client?

### 3.5 Chapter Summary

The primary task of this chapter was to introduce a critical review of professional and legal standards and literature on psychological records, with particular attention to distinct ethical pitfalls for closeted 2SLGBTQIA+ clients. Three main themes were addressed: ethical issues associated with etic frameworks; uncertainty among psychologists regarding how to approach charting; and the role of introspection, client equity, and aspirational guidelines in actualizing relational ethics in record keeping with 2SLGBTQIA+ clients.

In the next chapter, I will integrate this material into the context of a fictional case study concerning confidentiality threats for a closeted client associated with notetaking practices. Based on the information presented in this chapter, I will apply a variation of the CPA's (2017a) ethical decision-making framework to this dilemma to exemplify an emic, socially just approach to its resolution that corresponds with the premises of the feminist decision-making model (Hill et al., 1998) and the *Standards of Care for the Health of Transgender and Gender Diverse People*'s (Coleman et al., 2022).

# CHAPTER 4: ETHICAL DECISION-MAKING

In this chapter, I will position the corpus of literature described in Chapter 3 within a practical context. My intent in this endeavour is two-fold: Delineate the moral threats for 2SLGBTQIA+ clients established by current charting standards and give credence to the argument for supplanting universal ethical reasoning with emic, socially conscious modifications within the existing frameworks to ensure charting aligns with *the Code*. To provide context for this discussion, I will first describe potential strategies and resources for enhancing the CPA's model (2017a) for GI- and SO-related issues. After, a fictional case study will be presented, followed by an analysis of the dilemma according to a modified version of the CPA's 10-step framework, which was altered according to the suggested sources of information for ethical decision-making identified in Chapter 3.

## 4.1 Fictional Case Study

Lumina is a 29-year-old Albertan counselling psychologist practicing in an agency that holds a contract with a local university to provide counselling for their students. She begins seeing a new client, Drew, a self-referred 17-year-old student who is living on-campus for her first year. The client describes herself as a white, heterosexual, and middle-class person. Drew was forthcoming regarding her GI: She is a transgender woman who uses feminine pronouns (i.e., she/her/hers). She noted her primary reason for seeking therapy was to address her difficult experiences with cissexism and gender dysphoric symptoms. Drew shared that she plans to seek a formal diagnosis of gender dysphoria sometime in the near future.

The therapeutic relationship seems to develop well, and Lumina succeeds in adhering to organizational policy in her record keeping. However, as Drew is leaving the room in their second session, she requests adding an item for their next meeting's agenda: The client asks to discuss her experiences of being closeted to her parents and her fears regarding their highly favourable attitudes towards conversion therapy. These comments startle Lumina. During intake, the client stated that she was very open with her GI in her present life. Drew had noted that her parents raised her according to traditional gender norms as a child, but she described her parents as loving and warm in their current relationship. Drew did not reveal in this session that she was closeted, nor that her parents had expressed positive views of conversion therapy. Thus, the therapist did not foresee this potential risk of outing.

In line with the policies at Lumina's organization, clients aged 16 and above do not require parental consent for treatment, but the therapist is aware that because Drew is a minor, her parents hold the legal right to access her records and stop her treatment. Lumina immediately becomes concerned that their knowledge of the existence of Drew's records may encourage their efforts to access these documents. Given the nature of the client's presenting issues in the first session, the self report intake form and Lumina's notes explicated the gendered nature of Drew's challenges and hopes for counselling. The therapist is worried about the potential ramifications if the information in her notes were to be revealed to Drew's parents. Lumina identifies she is in moral conflict and needs to engage in an ethical dilemma decision-making process.

## 4.2 Definition of the Ethical Dilemma

### 4.2.1 The Dilemma

Does Lumina release the session notes to the client's parents if the latter evoke their legal right to access their minor daughter's records? To release the file to the parents without Drew’s consent constitutes a dilemma as disseminating this information infringes on the minor’s fundamental rights to autonomy, confidentiality, and privacy. Further, the content in the record outs the minor to her parents, who may not be supportive of Drew’s GI, thereby potentially inflicting psychological harm onto Drew and her parents and increasing the risk of physical violence for the client.

### 4.2.2 Background

Therapeutic services were provided under the assumption that Drew maintains the right to consent to her own treatment. This was judged according to agency and university policies and the client’s seeming capacity to make such judgements. Nonetheless, it is known by the therapist that parents have the right to give consent for their minor to access counselling, and with that right is the ability to access the files of their minor.

Although Lumina engaged Drew in a diligent, interactive process to acquire her informed consent, the therapist now debates whether her conduct was sufficient in this matter. Namely, it may have been the case that the conversation surrounding privacy and confidentiality required greater attention to sufficiently inform Drew of the confidentiality risks associated with session notes as they apply to her specific situation as a trans minor in the legal context described above. At this point, there appears to be insufficient information to determine whether the client fully comprehends these threats, or whether she has autonomously and thoroughly appraised the pertinent costs and benefits of documenting information indicating her TGD GI in her psychological records. Thus, the legitimacy of informed consent may be at stake.

## 4.3 Application of the CPA’s Ethical Decision-Making Procedure

This section will simulate the deliberative procedure for this dilemma according to the CPA's 10- step ethical decision-making model (2017a), which was reproduced from the CPA *Companion Manual* (2017b). The analysis was written from a first-person perspective (i.e., myself as Lumina) to exemplify typical decision-making documentation.

### 4.3.1 Step 1

Step 1: Identification of the individuals and groups potentially affected by the decision (CPA, 2017b).

In this step, I will specifically address the impacts on the following parties: Drew, her parents, myself, future students at the university counselling services, and society. These foci will be maintained subsequent steps of this appraisal to ensure the provision of appropriate attention to relevant individuals and groups in seeking an ethical resolution.

Drew (the client) is the primary individual I see being affected by this decision. However, her parents, myself (Lumina), future clients, my colleagues, and the agency all represent secondary parties implicated in the outcome of this deliberation. On the tertiary tier, my decision may also affect current and future minor and/or 2SLGBTQIA+ clients of this agency and society as a whole. Notably, my conduct in this matter also has the potential to shape the way in which 2SLGBTQIA+ people's privacy needs are recognized and handled within the domain of counselling psychology, other helping professions, and their ethicolegal governing bodies (e.g., the CPA and the legal system).

### 4.3.2 Step 2

Step 2: Identification of ethically relevant issues and practices, including the moral rights, values, wellbeing, best interests, and any other relevant characteristics of the individuals and groups involved, as well as the cultural, social, historical, economic, institutional, legal or political context or other circumstances in which the ethical problem arose (CPA, 2017b).

### ***Cultural Competence, Social Justice, and Client-Specific Needs***

The emergence of this dilemma implies that my lack of attention to cultural competence and social justice have resulted in a misestimation of Drew's circumstances and consequently her privacy and confidentiality needs. Cisheterosexism remains an extant societal norm, and as such, 2SLGBTQIA+ individuals often need to tread carefully with regard to the disclosure of their GI or SO. Remaining in the closet may be a matter of protecting one's safety, relationships, access to basic resources, and overall wellbeing. Threats to these needs, however, covary with each client's circumstances. Without knowledge of this context, therapists' ignorance is likely to lead to outing, and serious ramifications may rapidly materialize for closeted clients. Furthermore, if Drew lacks confidence in my ability to protect her secrecy or if my missteps lead to actual outing, then I may obstruct her right to participate in society by, for instance, endangering her social relationships or mitigating her willingness to access future counselling services. These outcomes contravene social justice as well as ethical and legal requisites for practice.

In this context, a measured, socioculturally aware approach addressing Drew's subjective needs and positionality is necessary. Thus, in accordance with the premises of the *Feminist Therapy Code of Ethics* (2000) and Canadian Counselling and Psychotherapy Association's (2020) virtue-based decision-making model, the analysis below pays particular heed to subjective experiences and manifestations of power, as opposed to an objective and generalist analysis that might be produced through a purely positivist lens. This integrated framework may also help restore Drew's power and autonomy, as well as her right to safeguard her own wellbeing.

### ***Relevant Principles and Standards in* the Code**

Using *the Code* (CPA, 2017a) chart as a framework, I can identify 27 standards spanning all four principles that seem to be relevant to this dilemma: 12 standards under Respect for the Dignity of Persons and Peoples, eight under Responsible Caring, three under Integrity in Relationships, and four under Responsibility to Society (see Table 1). Marrying these values categories and their potentially pertinent standards thus functions as a conceptual framework for my ethical exploration and reasoning. My views are summarised below, beginning with Principle I (see Table 2).

Table 1

*Principles Contained in the Canadian Code of Ethics for Psychologists and their Corresponding Values and Standards*

| **I. Respect for the Dignity of Persons and Peoples** | **II. Responsible Caring** | **III. Integrity in Relationships** | **IV. Responsibility to Society** |
|---|---|---|---|
| General Respect (1-4) | General Caring (1-5) | Accuracy/Honesty (1-8) | Development of Knowledge (1-3) |
| General rights (5-8) | Competence and self-knowledge (6-12) | Objectivity/lack of bias (9-12) | Beneficial activities (4-14) |
| Non-discrimination (9-11) | Risk/benefit analysis (13-17) | Straightforwardness/ openness (13-22) | Respect for society (15-18) |
| Fair treatment/due process (12-15) | Maximize benefit (18-27) | Avoidance of incomplete disclosure and deception (23-27) | Development of society (19-28) |
| Informed consent (16-26) | Minimize harm (28-39) | Avoidance of conflict of interest (28-32) | |
| Freedom of consent (27-30) | Offset/correct harm (40-47) | Reliance on the discipline (33-35) | |
| Protections for vulnerable individuals and groups (31-36) | Care of animals (48-54) | Extended responsibility (36-37) | |
| Privacy (37-42) | Extended responsibility (55- 56) | | |
| Confidentiality (43- 45) | | | |

| **I. Respect for the Dignity of Persons and Peoples** | **II. Responsible Caring** | **III. Integrity in Relationships** | **IV. Responsibility to Society** |
|---|---|---|---|
| Extended responsibility (46- 47) | | | |

Table 2

*Overview of Applicable Values and Standards in Principle I*

| Applicable Principle/Value/Standard | Unpacking the Standard as it Relates to the Dilemma: My Commentary |
|---|---|
| **Principle 1: Respect for the Dignity of Persons and peoples** | |
| ***Value: General respect*** | |
| I.1: Demonstrate appropriate respect for the knowledge, insight, experience, areas of expertise, and cultural perspectives and values of others, including those that are different from their own, limited only by those that seriously contravene the ethical principles of this *Code*. | Any decision made must demonstrate my respect for the client and her experiences, culture, and values, including those of privacy and confidentiality. Balancing these needs with documentation mandates (e.g., identifying the client's name and gender in their records) and the possibility of 3rd party viewership may require the adoption of creative recordkeeping practices. For example, although legal names may need to be placed on the informed consent document, in the future, one could record clients' GI-congruent names in the session notes or eliminate the use of gendered words full stop (e.g., "the client" in lieu of pronouns). |
| I.3 Strive to use language that conveys respect for the dignity of persons and peoples as much as possible in all spoken, written, electronic, or printed communication. | In creating their session notes, counselling psychologists might consider that respecting the dignity of the client entails the use of gender affirming language (Coleman et al., 2022) but also uses safeguards against potential outing. Thus, I would be wise to collaborate with Drew in determining the linguistic option that best balances these demands in her future session notes. |
| ***Value: General Rights*** | |
| I.8 Respect the moral right of research participants, primary clients, contract examinees, employees, supervisees, students, trainees, and others to safeguard their own dignity. | Clients must have the ultimate authority in determining whether to come out, and if so, how and to whom they do so. Thus, it may be sensible for me to avoid including any 'outing' information in future session notes unless Drew gives consent. |
| ***Value: Informed Consent*** | |

| Applicable Principle/Value/Standard | Unpacking the Standard as it Relates to the Dilemma: My Commentary |
|---|---|
| I.16: Seek as full and active participation as possible from individuals and groups (e.g., couples, families, organizations, communities, peoples) in decisions that affect them, respecting and integrating as much as possible their opinions and wishes. This would include respect for written or clearly expressed unwritten advance directives. Also, when working in an organizational or community context, it would include seeking participation of relevant individuals and subgroups that may not be represented by or may not have a role in formal leadership | This standard also seems to be pivotal in remediation and prevention efforts. Engaging ALL minor clients in an effective informed consent conversation may best allow for the joint identification of the best-fitting course of action. However, it may also be necessary to modify the content and delivery (e.g., age-appropriate syntax, vocabulary, and titration) of this conversation to optimize client comprehension and make it as participatory as possible (Bester et al., 2016; McBride, 2022). |
| I.23: Provide, in obtaining consent, as much information as reasonable or prudent individuals and groups (e.g., couples, families, organizations, communities, peoples) would want to know before making a decision or consenting to the activity. Typically, and as appropriate to the situation and context, this would include: purpose and nature of the activity; mutual responsibilities; whether a team or other collaborators are involved; privacy and confidentiality limitations, risks, and protections; likely risks and benefits of the activity, including any particular risks or benefits of the methods or communication modalities | I violated this standard by neglecting to seek Drew's assent to the documentation of sensitive outing information. Although I technically abided by professional regulations by sufficiently informing at Drew's consent for treatment, I may have neglected to inform her assent surrounding the confidentiality challenges with psychological records for minors (*Hopp v Lepp*, 1980).<br>In the spirit of transparency, autonomy, and fidelity, I should be open with Drew regarding the benefits and risks of my note taking style, and I should let her see what I have recorded in her file to date. I must also be forthright with Drew regarding the purpose of my documentation: My notes are not designed to support the pursuit of a medical transition, and if this is something that the client would like to seek in the future, she must seek help from a professional who specializes in this type of assessment. This must occur immediately. |

| Applicable Principle/Value/Standard | Unpacking the Standard as it Relates to the Dilemma: My Commentary |
|---|---|
| used; alternatives available; likely consequences of non-action; the option to refuse or withdraw at any time, without prejudice; over what period of time the consent applies; and how to rescind consent if desired. | |
| ***Value: Privacy*** | |
| I.37 Seek and collect only information that is germane to the purpose(s) for which consent has been obtained. | This standard seems to denote the need to predetermine consent and a rationale for any GI- or SO-revealing information before it is placed in the client's file. Therefore, perhaps a revision of the agency intake form is in order to ensure that sensitive information, which may need to be revealed to 3rd parties, is not sought until the client is aware of the contraindications to their privacy. |
| I.38 Respect the moral right of research participants, employees, supervisees, students, and trainees to reasonable personal privacy, and take care not to infringe, in research, teaching, supervision, or service activities, on the personally, developmentally, or culturally defined private space of individuals or groups (e.g., couples, families, organizations, communities, peoples), unless clear permission is granted to do so. | This seems to support the premise that clients have the ultimate authority to determine whether they come out and under which circumstances. Thus, it may be worth engaging the client in an exploration of individuals to which she is out and with which she consents to her GI being shared. Additionally, evaluating the subjective definitions of privacy and negotiating the language recorded may be instrumental in overcoming this issue. |
| I.39 Collect and record only that private information necessary for the provision of continuous, coordinated or collaborative service, or for the goals of the particular research study being conducted, or that is required or | Since it is noted, therapists collect information only when it is germane to do so. This standard represents a major source of strife with confidentiality and client safety, as Drew's presenting problem is specifically GI-related. To surmount this obstacle, the client and I could explore whether the transcription of more |

| **Applicable Principle/Value/Standard** | **Unpacking the Standard as it Relates to the Dilemma: My Commentary** |
|---|---|
| justified by law. (Also see Standards IV.17 and IV.18.) | ambiguous forms (e.g., replacing the term ‘cissexism’ with ‘prejudice’) would suffice. |
| I.41 Collect, record, store, handle, and transfer all private information, whether written or unwritten (e.g., paper or electronic records, e-mail or fax communications, computer files, recordings), in a way that attends to the needs for privacy, confidentiality, and security. This would include protection from loss or unauthorized access, appropriate education of staff or other agents, and having adequate plans in circumstances of one’s own serious illness, termination of employment, or death. | A creative approach may be required to achieve this standard in the case that TGD clients are uncomfortable with their GIs being known by other agency staff. For instance, when labelling session notes, utilizing a client number in lieu of their name may better protect our TGD clients from the recognition of their GI if this name is incongruent with the one used outside of the counselling room. |
| ***Value: Confidentiality*** | |
| I.43 Be careful not to relay incidental information about colleagues, team members, other collaborators, the primary clients or contract examinees of others, research participants, employees, supervisees, students, or trainees gained in the process of their activities as psychologists, that the psychologist has reason to believe is considered confidential by those individuals or groups, except as required or justified by law. (Also see Standards IV.17 and IV.18.) | This standard is of special importance for TGD clients. It is considered best practice to utilize gender affirming language (Coleman et al., 2022; Potter, 2020), but it is also important to explicate differential limits to confidentiality when these terms are used verbally and in sessions versus recorded into the client’s psychological record. If recorded in the client’s records, gender affirming language might thus breach confidentiality by outing the client’s GI. |
| I.45 Share confidential information with others only to the extent reasonably needed for the purpose of sharing, and only | This point underscores exigencies of consent and rationale (e.g., a serious risk of imminent harm) in deliberating whether to disclose. For instance, if |

| Applicable Principle/Value/Standard | Unpacking the Standard as it Relates to the Dilemma: My Commentary |
|---|---|
| with the informed consent of those involved, or in a manner that the individuals and groups (e.g., couples, families, organizations, communities, peoples) involved cannot be identified, except as required or justified by law, or in circumstances of possible imminent serious bodily harm. (Also see Standards II.42, IV.17, and IV.18.) | disclosing Drew's confidential information poses a threat to her safety, I may need to refuse to do so.<br>It important to avoid assuming that 2SLGBTQIA+ clients are comfortable with their SO or GI being shared with other providers, even if they have come out to their psychologist. Demarcating the confidential or private nature of this data and only disclosing it on a 'need to know' basis" (e.g., only revealing it to those within the client's circle of care that require it; Coleman et al., 2022) might assist with achieving this task. I may also consider anonymizing Drew's information during consultation, supervision, and other interprofessional activities. |
| ***Value: Extended Responsibility*** | |
| I.46: Encourage others, in a manner consistent with this Code, to respect the dignity of persons and peoples, and to expect respect for their own dignity. | I may need to encourage organizational record keeping policy reform, especially with regard to those surrounding privacy and confidentiality, to promote respect and dignity for our 2SLGBTQIA+ clients. In particular, I believe that advocating for the revision of our intake forms and the universal use of gender-neutral terminology and client identification numbers (to replace their names) in session notes may be of value in this mission. |

In summary, Principle I, Respect for the Dignity of Persons and People, is considered the most important value for the profession and society (CPA, 2017a) and warrants the greatest consideration when engaging in ethical decision-making. This essence of this category is the protection of universal human worth and rights, both in a moral and judicial sense. Principle I demands respect for the subjectivity and diversity of all people. With respect to documentation of 2SLGBTQIA+ clients, this might mean attributing significantly more weight to their privacy and confidentiality needs in data collection and management. One such possible method is the shift towards gender neutral or less descriptive language, progress- or change-focused notes (Hutchinson et al., 2008; McBride, 2022) while utilizing verbal gender-affirmations within the confidence of the counselling sessions. These protection-focused efforts also represent a core endeavour for the next value category: Principle II, Responsible Caring (see Table 3).

Table 3
*Overview of Applicable Values and Standards in Principle II*

| **Applicable Principle/Value/Standard** | **Unpacking the Standard as it Relates to the Dilemma: My Commentary** |
|---|---|
| **Principle II: Responsible Caring** | |
| ***Value: General Caring*** | |
| II.1 Protect and promote the well-being and best interests of primary clients, contract examinees, research participants, employees, supervisees, students, trainees, colleagues, team members or other collaborators, and others. | As a vulnerable population, 2SLGBTQIA+ clients require exceptional diligence in protecting their wellbeing and enhance their moral rights. Charting practices with primary clients from this demographic must reflect this position and a commitment to social justice. Therefore, I shall strongly consider utilizing exploratory dialogue and informed consent procedures to collaboratively determine my client's needs. These methods will also provide means to expound Drew's needs and potential safety risks (e.g., if she is strongly concerned about her safety in the case that her parents learn of her GI). These actions would need to be taken before any charting in the next session. |
| II.2 Avoid doing harm to primary clients, contract examinees, research participants, employees, supervisees, students, trainees, colleagues, team members or other collaborators, and others. | This is a crucial standard for all 2SLGBTQIA+ clients in the closet, but particularly so for this dilemma since Drew's age may reduce her social power. Accidental or not, disclosing the client's GI in her psychological record may exacerbate an already fraught situation of safety. Even if I do not endanger her physical safety, outing Drew robs her of her dignity, autonomy, and privacy; threatens |

| **Applicable Principle/Value/Standard** | **Unpacking the Standard as it Relates to the Dilemma: My Commentary** |
|---|---|
| | her relationships; and evokes a substantial risk of mental distress. |
| II.5 Make every reasonable effort to ensure that psychological knowledge is not misinterpreted or misused, intentionally or unintentionally, to harm others. | It is possible that this standard is at risk. My session notes contain outing information and thus may pose a significant threat to her safety, if, for instance, used to justify her mistreatment. For example, cisheterosexist parents may use this information to justify conversion therapy. Given its well-documented, egregious threats to 2SLGBTQI+ clients' safety as well as its potential moral and human rights violations, conversion therapy represents an extremely dangerous and scientifically unproven practice (*Act to amend the Criminal Code*, 2021; CPA, 2023; United Nations Human Rights Council, 2020).<br>In determining how to ameliorate this dilemma, the "level of action would need to be proportionate to the level of potential harm" (CPA, 2017b, p. 92). With that being the case, I may need to take swift action, informing Drew of what is in her file, exploring with her the potential likelihood of these risks, creating a safety plan, and developing a style of notetaking that better respects safety-related privacy needs. |
| II.10 Evaluate how their own experiences, attitudes, culture, beliefs, values, individual differences, specific training, external pressures, personal needs, and historical, economic, and political context might influence their interactions with and perceptions of others, and integrate this awareness into their efforts to benefit and not harm others.<br>***Value: Risk/benefit analysis*** | As a cisgender person, I need to reflect on how my lack of lived experience, training, and education with issues specific to TGD identities may obscure my applicable charting competencies (also see II.14). Notably, deficiencies in these areas may have already heightened outing risks due to my inattention to Drew's unique privacy needs as a young TGD person. It appears that lessening these risks requires improving my reflexivity and increasing relevant competencies through professional development, consultation, and supervision from experts and TGD people themselves. |

| **Applicable Principle/Value/Standard** | **Unpacking the Standard as it Relates to the Dilemma: My Commentary** |
|---|---|
| II.14 Be sufficiently sensitive to and knowledgeable about individual and group characteristics, culture, and vulnerabilities to discern what will benefit and not harm the individuals and groups (e.g., couples, families, organizations, communities, peoples) involved in their activities. | Like standard II.10, I failed this directive through my ignorance to the risks of and potential mechanisms for outing as they relate to my notetaking practices. I need to improve this area of competence to establish appropriate sensitivity and safeguards for this vulnerable demographic. On top of efforts to increase my competence through training and support, there is value in working with Drew to identify how we can best benefit her and reduce the possible risks associated with my current style of notetaking. |
| ***Value: Maximize benefit*** | |
| II.21 Create and maintain records relating to their activities that are sufficient to support continuity and coordination over time and to manage risks. | This standard represents the crux of the current dilemma. Namely: (1) Charting personal health information may cause it to become available to other providers or 3rd parties, which risks outing clients who do not wish to disclose their GI status; (2) It seems necessary to conceal any references to Drew's trans GI, but at the same time, this information is central to the client's presenting problem, which needs to be documented for continuation of care. Overall, I am concerned about how its exclusion in the file may affect Drew and interfere with the quality of the services from her other care providers. To remediate this conflict, I appreciate the need to explicate the potential benefits and risks of my notetaking style to Drew then consider a record keeping practice that optimize beneficence and nonmalfeasance. |
| ***Value: Minimize harm*** | |
| II.32 Be acutely aware of the need for discretion in the recording and communication of information, in order that the information not be misinterpreted or misused to the detriment of others. This includes, but is not limited to: not recording or | For closeted TGD clients, some commonly collected information has the capacity to out them, but this information may also be required for the provision of continuous, coordinated, and collaborative care. This standard thus conflicts with standard I.3, I.39, I.41, I.43, and II.21. |

| **Applicable Principle/Value/Standard** | **Unpacking the Standard as it Relates to the Dilemma: My Commentary** |
|---|---|
| communicating information that could lead to misinterpretation or misuse by those having access to or receiving the information; avoiding conjecture; clearly labelling opinion; and communicating information in language that can be understood clearly by the recipient of the information. | Since Drew noted that she uses she/her/hers pronouns, this is the optimal choice for gender-affirmation; however, I may need to consult with Drew to identify which language we can use in charting to best limit the risks of misuse (e.g., outing). If Drew is disinclined to come out to her parents, she may request that I use the pronouns by which her parents refer to her (i.e., he/him/his) or those that are gender neutral (e.g., they/them/theirs) in my notes. Based on my analysis, it appears to be essential that Drew makes the ultimate decision in this situation. I want to avoid misgendering so I must intentionally and carefully proceed, ensuring the course of action reflects Drew's informed choice by providing her with the time and space needed for her to weigh the risks, alternatives, and benefits. |
| ***Value: Extended responsibility*** | |
| II.55 Encourage others, in a manner consistent with this Code, to care responsibly. | Advocating for Principle II in my place of work is indicated by this standard. Although its philosophies promote a support for the 2SLGBTQIA+ community, the agency's one-size-fits-all consent and charting policies as well as those of the general profession may fall short in shielding the rights of this demographic. |

The essence of Principle II is a demonstrable commitment to fiduciary responsibilities: beneficence, nonmalfeasance, and a genuine concern for clients. In their notetaking practices with 2SLGBTQIA+ clients, psychologists may encounter a conflict between the need for detailed information for the provision of services and minimizing harm when releasing client data. These risks are even more serious when counsellors remain uninformed or inattentive to the specific vulnerabilities of this demographic.

Professionals require specific training and support in the ethics of recordkeeping with 2SLGBTQIA+ clients. In addition, clients need to be engaged in a thorough and collaborative examination that explications the therapist's notetaking process and the extent to which the client's GI is included in their file. To temper potential risks, both members of the alliance need to pay heed to these recommendations by conducting a joint risk-benefit analysis of the proposed notetaking style. Nonetheless, before they can implement this knowledge, I advocate that therapists must be honest with themselves regarding their competence in working with 2SLGBTQIA+ clients, as mandated by Principle III, Integrity in Relationships (see Table 4).

Table 4

*Overview of Applicable Values and Standards in Principle III*

| **Applicable Principle/Value/Standard** | **Unpacking the Standard as it Relates to the Dilemma: My Commentary** |
|---|---|
| **Principle III: Integrity in Relationships** | |
| ***Value: Straightforwardness/openness*** | |
| III.13 Be clear and straightforward about all information needed to establish informed consent or any other valid written or unwritten agreement (e.g., fees, including any limitations imposed by 3rd party payers; relevant conflicts of interest; relevant business policies and practices; contact information of accountability bodies; mutual concerns; mutual responsibilities; ethical responsibilities of psychologists; likely experiences; possible conflicts; possible | Clients that identify as 2SLGBTQIA+ require a clear explanation of the standard charting practices and commonly collected data that have the potential to reveal their SO or GI (e.g., descriptions of the presenting problem, the use of same-sex partners as emergency contacts, or the inclusion of gendered information for TGD clients). It would be best to relay this type of consent information in a manner that supports her comprehension and retention. With Drew, I need to consider how to best deliver this conversation at an age-appropriate level and ensure that I revisit the topic to refresh her memory or as new relevant issues emerge. |

| Applicable Principle/Value/Standard | Unpacking the Standard as it Relates to the Dilemma: My Commentary |
|---|---|
| outcomes; and expectations for processing, using, and sharing any information generated). | |
| III.16: Fully explain reasons for their actions to the individuals and groups (e.g., couples, families, organizations, communities, peoples) that have been affected by their actions, if appropriate and asked. | If I choose to break organizational policy or professional standards by refusing to share my notes with approved parties, then I must be able to evidence the necessity of these actions in the file, to Drew, her parents, my colleagues, superiors, and regulatory officials. |
| ***Value: Reliance on the discipline*** | |
| III.35: Seek consultation from colleagues and/or appropriate others, including advisory groups, and give due regard to their advice in arriving at a responsible decision, if faced with a difficult situation. | These actions are compulsory according to the feminist ethical decision-making model (Hill et al., 1998), the *Standards of Care for the Health of Transgender and Gender Diverse People* (Coleman et al., 2022), and in the context of the counsellor's lack of knowledge and training with regarding to TGD issues and ethical threats (pursuant to the value of competence and self-knowledge under Principle II). |

In sum, Principle III is the focus of this dilemma, as it conveys the necessity of honesty, accuracy, and clarity in explicating relevant information (CPA, 2017a). With 2SLGBTQIA+ clients, each clinician should evaluate their attitudes, knowledge, and blind spots associated with the situation (APA, 2021), and they must also discuss the risks and alternatives to their notetaking practices. Similarly, it would be important to seek guidance from knowledgeable professionals if a lack of ethical competence is identified for this issue. These practices may also underline the need to proceed carefully with note keeping for closeted clients to main compliance with a socially just approach, which closely relates to Responsibility to Society (i.e., Principle IV; see Table 5).

Table 5

*Overview of Applicable Values and Standards in Principle IV*

| Applicable Principle/Value/Standard | Unpacking the Standard as it Relates to the Dilemma: My Commentary |
|---|---|
| **Principle IV: Responsibility to Society** | |
| ***Value: Development of knowledge*** | |
| IV.8: Engage in regular monitoring, assessment, and reporting (e.g., through peer review; in program reviews, case management reviews, and reports of one's own research) of their ethical practices and safeguards. | Based on the significant outing threat that has occurred, reviewing and ameliorating my practices and the organization's policies may be in order. I could consider bringing collegial attention to this issue and the need for reform to uphold the dignity of current and future 2SLGBTQIA+ clients. These actions also abide by the responsibilities set forth in step 10 of the CPA's ethical decision-making model (2017a). I would also inform Drew that I will strive to learn from my mistake for her benefit and that of other 2SLGBTQIA+ clients. |
| ***Value: Development of society*** | |
| IV.20 Be sensitive to the needs, current issues, and problems of society, when determining research questions to be asked, services to be developed, content to be taught, information to be collected, or appropriate interpretation of results or findings. | This standard seems to indicate that I have a duty to enhance my awareness of the experiences and specific needs of my TGD clients in my practices. This position may also imply that these represent requisites for selecting which data to collect and record in session notes. |
| IV.21 If their work is related to societal issues, be especially careful to keep well informed of social, cultural, historical, economic, institutional, legal, and political context issues through relevant reading, peer consultation, and continuing education. | Because my current case load includes several other 2SLGBTQIA+ clients, I need to consider taking immediate action to repair the deficits in my knowledge through professional development, consultation, and supervision. These precautions may help prevent future occurrences of outing while increasing potential benefits in my clinical activities. |

| Applicable Principle/Value/Standard | Unpacking the Standard as it Relates to the Dilemma: My Commentary |
|---|---|
| IV.28 Speak out and/or act, in a manner consistent with the four principles of this Code, if the policies, practices, laws, or regulations of the social structure within which they work seriously ignore or contradict any of the principles of this Code. | It seems necessary to draw attention to this issue for large-scale remediation. I may need to raise awareness of this issue to my agency, as our current one-size-fits-all policies seem to conflict with the ethical standards of this *Code* (2017) for our 2SLGBTQIA+ clients (e.g., the requirement to document the client's name and pronouns and a enter detailed information beyond that the presenting problem). |

The premise of Principle IV, Responsibility to Society, speaks to the need to address inefficacious and unethical bearings of the profession, particularly as they affect 2SLGBTQIA+ and other marginalized groups. Analyzing this value category revealed that in the case of charting, the absence of psychologist-client privilege is one such influence with the capacity to aggravate the existing hardships of 2SLGBTQIA+ clients. This principle speaks to the need to advocate for the remediation of this issue on a broader tier. Therefore, calling for the revision of this ethico-legal challenge across the field seems to represent a core endeavour within the fiduciary role.

### *Analysis of Step 2*

This detailed examination of step 2 revealed a need to direct efforts towards equity in the consent process surrounding the protection of closeted clients' records. In defending the rights of this community, conscientious consideration of their marginalized position is indicated by *the Code.*

Principle IV has sparked my desire to advocate for minors—if they have the capability—to have the same legal rights to provide informed consent and govern their files as adults (Brooks et al., 2011; *JSC v Wren*, 1986; CAP, 2022). This is a long-term plan to bring forth the essence of Principle IV. In the meantime, my focus must remain on Drew. Since she is my primary client and I have deemed her a vulnerable minor, this analysis, particularly Principle III, has reminded me that my primary obligation is to prevent harm (Brooks et al., 2011; CAP, 2022; CPA, 2017a). It is imperative that I accept responsibility for my failure to conduct a thorough consent process regarding file management. In addressing this mistake, I should include Drew and relevant others (e.g., my lawyer and supervisor) in decision-making regarding this client's records.

#### *An Additional Step: Consultation*

At this point, I may also consider following the guidance of the feminist decision-making model (Hill et al., 1998), which suggests seeking pertinent information through research, supervision, and other appropriate data sources. Most notably, however, client consultation may impart indispensable information to clarify the circumstances underlying this dilemma. Drew is truly the expert when it comes to matters of her life; she is the only one who can explicate her needs and goals. Unfortunately, since Drew has already departed from our session, I am unable to consult with her at this point, but I will take great care to begin so when I next have the opportunity.

### 4.3.3 Step 3

Step 3: Consideration of how one's own biases, external pressures, personal needs, self-interest, or cultural, social, historical, economic, institutional, legal, or political context and background, might influence the development of or choice between courses of action (CPA, 2017b).

Beyond the factors described in this step, other influences require consideration. This includes the biases of *the Code* (CPA, 2017a) and clinicians' emotional and intuitive experiences.

#### *The Biases of Ethical Tools*

Ethical tools are not value-free (Walsh, 2015; Ward, 2017), and ignorance to this fact may skew decision-making according to their biases. In this case, for example, the lack of a mandatory interpersonal component, especially client consultation, in the CPA's model may exacerbate the blind spots to my subjectivity (Williams, 2004) and the existence of outing threats. Additionally, as a socially situated issue, the heterosexist undercurrents of this dilemma clash with the values communicated in professional priorities. Namely, Principle IV holds higher value in this dilemma than that specified in *the Code*, thereby suggesting that reweighting is needed.

### ***Intuition and Embodied Experiences***

Like the CPA (2017a) noted, exploring subjectivity is imperative, but I believe in an expanded view of this task. Namely, deepening my reflexivity by examining my emotional and intuitive reactions may help me identify relevant biases, voids of knowledge and experience, desires, and other personal influences that might remain uncovered if I attempted to remain objective and distant in my appraisal.

### ***Personal Biases, Needs, and Self-Interests***

The presence of authority bias was evidenced by my obedience to a colonized consent process without attention to nuances associated with each client. I knew the agency's consent process was not relational (McBride, 2018), and yet I failed to advocate for our clients. I need to identify the origins of my reluctance to confront my agency's leaders regarding the issues with our consent process and those surrounding minors' access to counselling in the absence of parental consent.

However, the problem remains what to do with Drew's file if the parents request it. This issue requires me to identify my seemingly misguided rationale for the quantity of detail that I entered into my session notes. There are several possibilities that I believe may underlie this error, such as limited training in notetaking, little practice with TGD clients, and a poor understanding of the process by which individuals pursue gender-affirming medical care. I strongly believe in Drew's right to self-determination and autonomy, particularly as it applies to coming out and GI. However, I failed to recognize how these attitudes fostered blind spots in my documentation and encouraged me to do what *I* thought was best instead of what was *actually* best for my client. Indeed, the presence of this dilemma may suggest that I have overestimated my competence in working with this demographic, and thus, consultation may be called for at this stage.

Perhaps my social identity also influenced my decisions. As a cisgender woman, my GI aligns with the hegemonic gender dichotomy despite marginalization within patriarchal systems. Furthermore, though I am a SO minority, my subgroup within the 2SLGBTQIA+ community is more readily accepted by society and better understood by the field than our TGD counterparts. I also have the privilege of an accepting family. Thus, I did not adequately consider the precarity of Drew's positionality because I did not compensate for my lack of first-hand experience or training in TGD stigma.

Though 3rd parties have sought my clients' records in the past, for the first time, I notice myself trembling, sweating, and experiencing a tightness across my chest when I imagine Drew's parents making such a bid. Why is this situation different? After pondering this, I realize that these physiological responses may relate to previous experiences. The prospect of conflicts pertaining to identity politics, especially those involving individuals who are straight, white, and/or identify as cisgender men, evokes trepidation because of personal experiences with violence and discrimination from individuals from this demographic that directly related to my identity as a queer, racialized woman. At the same time, I recognize I am assuming the worst about Drew's parents, likely due to clouding from the personal history I have just described. I must be circumspect to prevent presumptuous conduct in this situation. I am not permitted to analyze or judge others without their consent, and if I am given the honour to meet Drew's parents, I need to show them respect, dignity (Principle I) and care (Principle II and III). However, I must also continue to position Drew at the centre of my efforts and protect her privacy according to her direction.

### ***External Pressures***

I may need to bring attention to and push back against the standards implicated in this issue, but I am apprehensive at the prospect of raising these concerns. At my agency, it is the norm to divulge significant detail in charting, and I feel pressured to comply. I am also afraid of encountering criticism from regulatory bodies for failing to disclose a sufficient degree of information in my records, which might threaten my ability to practice as my career is integral for my identity and financial resources.

### ***Cultural, Social, Historical, Economic, Institutional, Legal, or Political Context and Background***

I believe TGD people represent one of the most marginalized populations in contemporary Canadian society, including in the field of psychology itself. Although the mistreatment and pathologization of these GIs is often thought to be purely historical, I have observed these outcomes during my tenure, and I have noticed a deficiency in training for practice with TGD clients among clinicians. I may also be guilty of these errors, and I am bound to halt their occurrence.

Besides the hegemonies that produce cisheterosexism, other manifestations of disparate power also exert influence. As adults, both I and the client's parents hold greater social and legal power than the client. Drew's parents have the right to access her files, and they might also have the legal authority to determine her medical and mental health care, though I do not believe this is the case in this situation. My role also enhances my social power and authority, the latter of which permits me to simply begin reducing the amount of detail in her future session notes. Nevertheless, taking this route constitutes using my power *over* the client instead of *with* her. For me to do so would be to negate client autonomy, violate the premises of the right use of power, and discard the opportunity to draw from collective power as an anecdote for systemic injustice. Albeit authorized, acting without client consultation may also disturb Drew's trust in her providers, consequently dissuading her from accessing future support. It is important to add that I may be required to use my power and independently break confidentiality to ensure Drew's safety. These actions are not presently mandated due to the current lack of foreseeable or imminent harm (CPA, 2017a), but it will be important to monitor and mitigate this risk as much as possible. If these instances arise, I will inform the client and involve her in decision-making to the fullest extent possible.

### 4.3.4 Step 4

Step 4: Development of alternative courses of action regarding how to handle her file, if/when the parents request Drew's file.

Regardless of the course of action selected, I will also immediately proceed with the following steps: (i) seek training on ethics with TGD clients and recordkeeping to support this goal; (ii) seek consultation or supervision on my options; and (iii) to mitigate the outing risks posed by recordkeeping, decrease the amount of gendered information recorded by involving the client in the notetaking process (i.e., relational session notes; McBride, 2018) and documenting only that required to advance therapeutic processes. Furthermore, I am aware I have several additional options.

### *Alternative 1*

I will not communicate to Drew what is in her file in hopes that no one requests her file until she has identified that she is ready to manage the consequences of coming out and thus independently takes steps to disclose her GI. Overall, I will implement this decision without alerting the client and this option is permitted by my scope of authority (Bester et al., 2016; CPA, 2017a).

### *Alternative 2*

I would close her first file and open a new one. If Drew's parents request her file, I would offer them the second (newest) one, in hopes that they do not request "all" files concerning their daughter. I would not communicate this action plan with Drew nor my reasoning to avoid upsetting the client and worrying her unnecessarily.

### *Alternative 3*

At a relevant point during the next session, I would carefully—without revealing any of the biases or fears I carry about the parents—invite the client to share her thoughts and feelings about her parents and inquire if they know about her journey surrounding her GI. During this discussion, I would sensitively communicate that my notetaking practices included documenting information related to her presenting concern as needed for the continuity or collaboration of her care. I would then create space for her to react to the contents of her session notes and explore the implications of these records, namely, in terms of the potential outcomes in the case that her parents were to access and view this personal information. Additionally, I would stress that I would like to help Drew learn about means to protect her file from being released (e.g., refer her to a lawyer) if she so desires.

### 4.3.5 Step 5

Step 5: Analysis of likely short-term, ongoing, and long-term risks and benefits of each course of action on the individuals and groups involved or likely to be affected, taking into account relevant individual and cultural, social, historical, economic, institutional, legal, and political contextual factors.

Despite my pursuit of ethicality, I am aware that there may not be a unilaterally optimal solution to this dilemma, especially given the complexity of the situation and my presumptuous previous actions. Given these circumstances, it may be even more important to determine which option offers the best protection for the client in this situation. My appraisals of the potential courses of action are summarized below (see Tables 6-8)

Table 6
*Possible Positive and Negative Consequences of Alternative 1*

| Possible Positive Consequences | Possible Negative Consequences |
|---|---|
| I may be less likely to rupture the therapeutic alliance or evoke client distress if this issue is not brought to Drew's attention. | This does not remediate the issue of outing at-hand. Her files might be requested prior to Drew's coming out, in which case, there is a risk that I will be responsible for betraying her confidence, relationships, or safety. |
| I might decrease the risks of outing Drew to 3rd parties by remediating this issue discreetly. | The client would remain unaware of the outing information contained in her notes. Thus, these actions misalign with informed consent requisites and the right to self-determination. She would also be unable to fully consider these risks when |

| Possible Positive Consequences | Possible Negative Consequences |
|---|---|
| | deciding whether to provide 3rd party access. |
| Because these actions are inconspicuous, they may prevent backlash from Drew's parents, my colleagues, supervisor, and other third parties in the short-term. | In the long-term, this option fails to bring attention of this dilemma to Drew and other professionals in field so they may avoid and attempt to remediate this issue. |
| These actions can be implemented immediately, and little effort is required in implementing this choice. | |

Table 7
*Possible Positive and Negative Consequences of Alternative 2*

| Possible Positive Consequences | Possible Negative Consequences |
|---|---|
| If, upon presenting the new record to Drew's parents or other 3rd parties, it is *prima facie* believed to be the sole record, then they may never learn of the existence of the previous file containing the damaging information, thereby alleviating the risks of outing and backlash. | The existence of the original file may be determined (e.g., by identifying the absence of early session dates) and sought, thus continuing the outing risks for Drew. |
| Because the client would remain in the closet, so to speak, regarding this ethical issue, this option may prevent her distress and preserve her trust in the fiduciary relationship. | Deciding without Drew's assent reinforces hierarchical power and undermines her trust in her providers. Thus, I would be making a unilateral, decision with substantial potential risks. |
| These autonomous actions represent a way to fulfill my professional duties while avoiding the potential challenges and messiness of trying to inform the minor client of complicated legal issues implicated in decision-making. | Without fully informing the client of the potential threats associated with her records, I invalidate the consent contract and encroach on moral rights (e.g., autonomy and dignity) and fiduciary responsibilities (e.g., integrity in relationships and responsible caring). |

| Possible Positive Consequences | Possible Negative Consequences |
|---|---|
| This option requires little to no time from our sessions, meaning we can continue to focus on our work towards her clinical goals. | I could be perceived to be hiding my previous, unethical conduct and thus may be penalized by professionals or the 3rd parties seeking Drew's records. |

Table 8

*Possible Positive and Negative Consequences of Alternative 3*

| Possible Positive Consequences | Possible Negative Consequences |
|---|---|
| By opening up this discussion, an opportunity is created for ongoing exploration with Drew about whether she is out to her parents or other parties, whether they are supportive of TGD individuals, and whether she is safe, we can monitor her wellbeing and ensure that our approach to notetaking factors in these considerations. | Drew's awareness of this issue may evoke distress, which may spur her to inform her parents about this dilemma. Even if the client does not reveal her GI to these individuals, their knowledge of this issue may encourage them to seek the original documents. If any 3rd party discovers the client's GI through this process, then she may face real risks to her safety and relationships. |
| Developing Drew's knowledge of her rights, confidentiality threats, and the content of her psychological record may enhance her ability to actualize her self-determination both now and with future providers. Thus, it aids her in utilizing her legal and moral rights for self-protection both now and in the future. | Drew's age complicates this matter, as the opportunities to access her records are numerous and as a young person, her comprehension may be inhibited by her cognitive level and limited legal knowledge. |
| Informing Drew of the situation and ethico-legal considerations also provides an opportunity for her to inform my knowledge regarding the circumstances surrounding the concealment of her GI. This information will help mitigate the biases and limitations that seclude my | Although I am seeking Drew's assent and input into decisions, client-practitioner power imbalances may interfere with her capacity to raise objections, especially given her age and social location. |

| Possible Positive Consequences | Possible Negative Consequences |
|---|---|
| ability to identify relevant factors and potential risks. | |
| This form of collaborative decision-making may equity within the alliance and encourage Drew’s use of power and self-determination beyond our relationship. | By bringing the client’s attention to this ethical issue, I may face increased risks to litigation or professional reprimand. |
| | This is the most time consuming and complicated choice of action. |

### 4.3.6 Step 6

Step 6: Choice of course of action after conscientious application of existing principles, values, and standards (which includes but would not be limited to relevant laws and regulations).

As Drew’s therapist, my duty to protect her confidence and safety remains in place, and thus, I must invite Drew to participate in an improved informed consent process regarding her file and general protections. Based on this, and the detailed analysis in step 2 and 5, I deem alternative 3 as the most honest and direct course of action.

This selection also coheres with relevant, supplementary guidelines. For example, as a collaborative approach, it is substantiated by ethical guidelines premised upon emic, socioculturally contextualized tenets, and principles of social justice (Calder, 2022; Coleman et al., 2022; Hill et al., 1998; Papadopoulos, 2018; Walsh, 2015; Ward, 2017). This attribute also aligns with the right use of power, as suggested by Barstow (2021). Finally, the determined course of action would also appear to satiate tests for appraising counsellors’ ethical conduct (e.g., the tests of publicity and universality; Canadian Counselling and Psychotherapy Association, 2020).

### 4.3.7 Step 7

Step 7: Action, with a commitment to assume responsibility for the consequences of the action.

There are several steps involved in this course of action that may create complicated or adverse outcomes. Whatever the outcome, however, I am required to take accountability for my actions (CPA, 2017a, II.3).

### 4.3.8 Step 8

Step 8: Evaluation of the results of the course of action.

Ongoing attention is needed with regard to consent, privacy, and safety. For instance, I must pay close attention to Drew's perceived comprehension of this issue and act appropriately to ensure the validity of consent, particularly due to the client's developmental level and the need for information to be presented continuously and in a titrated manner. I will need to consistently monitor her situation regarding safety and GI concealment to identify if there is a need to report to the relevant authorities, as would be the case if a serious risk of foreseeable, significant harm emerges for Drew or another person (Child, Youth and Family Enhancement Act, 2000; CPA, 2017a, II.42). A necessary constituent of this monitoring is client consultation, which must gently probe whether she is out and supported, and/or facing any potential risk factors.

### 4.3.9 Step 9

Step 9: Assumption of responsibility for consequences of action, including correction of negative consequences, if any, or re-engaging in the decision-making process if the ethical issue is not resolved.

After identifying the particulars regarding to whom Drew is out, we must engage in collaborative decision-making to coordinate a plan for the use of GI-referential information across settings and bystanders. For example, if Drew is out to the staff at the agency but not to her parents, we might decide to use her GI-congruent pronouns in referring to her verbally or in private areas of the office (e.g., rooms with a shut door), but any public or written reference might require the use of gender neutral pronouns (e.g., they/them/theirs) or those associated with her dead GI (e.g., he/him/his). This plan should be revisited each time pertinent events or information arise. This dialogue thus elucidates whether the client's GI is confidential to those outside of therapy and what other precautions must be implemented.

I must also be vigilant for any ramifications of my actions. Quandaries—whether they be safety-related, clinical, ethical, or otherwise—may arise from my erroneous conduct or my amelioration efforts. Due to the potential relational fractures associated with the course of action, remedying cracks within the alliance is a key facet of this obligation, one which will also facilitate treatment efficacy. Similarly, providing Drew with resources specific to 2SLGBTQIA+ youth may improve clinical outcomes (Potter, 2020). We will co-determine with which external supports may fit her needs in response to situational demands. For example, I can offer Drew a referral to a psychologist more competent in practicing with 2SLGBTQIA+ youth, if she so desires. If Drew would like to continue working together but is deterred from discussing GI-related topics due to outing fears, then I may tentatively suggest the supplemental use of an anonymous helpline dedicated to 2SLGBTQIA+ individuals or TGD youth specifically. Moreover, my plan is incumbent on Drew's continued decision-making competence. Upon the discovery that the client is unable or too overwhelmed to assume this responsibility, then I may need to re-engage ethical reasoning to address this reneged presumption.

I recognize that I have been presumptuous towards Drew's parents in the absence of evidence substantiating this line of thinking. Therefore, it is essential that I receive personal counselling to absolve my issues so I can remain impartial towards those who may hold different values than myself. This endeavour represents an important avenue for treating the parents with the respect and neutrality of which they are deserving.

### 4.3.10 Step 10

Step 10: Appropriate action, as warranted and feasible, to prevent future occurrences of the dilemma (e.g., communication and problem solving with colleagues and team members or other collaborators; changes in procedures and practices).

To uphold Principle IV, Responsibility to Society (CPA, 2017a), necessitates the improvement of the discipline (Sugarman, 2015). If I were to neglect this responsibility, then my peers may remain uninformed to these ethical perils, and thus 2SLGBTQIA+ clients may encounter similar outing threats. Therefore, it is my duty to articulate these confidentiality risks to those within the field. A commensurate responsibility is agency-level advocacy for consent process reform to address the ethical challenges associated with our current detached and universalist approach. By espousing a relational, self-aware, and socially just lens, these efforts may improve mine and my peers' conduct, in such a manner that nears coherence with contractual demands and aspirational ethics. Additional recommendations associated with Step 10 are embedded throughout this project. Given the extensive length of this chapter, they will not be repeated here but will be presented in the next chapter.

## 4.4 Chapter Summary

The intent of Chapter 4 was to highlight subjectivity and emic considerations demanded by the pursuit of ethical axioms, particularly as they apply to service with

TGD clients and those affected by stigma. A description of benefits, limitations, and potential supplementary resources for the CPA’s ethical decision-making model (2017a) was provided with a particular focus on the topics implicated in the case study. This analysis was oriented in holism and social justice while remaining compliant with the broad framework presented in *the Code* (CPA, 2017a). Following this section is Chapter 5, which will describe general recommendations for charting with 2SLGBTQIA+ counselling clients.

# CHAPTER 5: RECOMMENDATIONS FOR CHARTING WITH 2SLGBTQIA+ CLIENTS

As a result of the extensive analysis of *the Code* (see Chapters 3 and 4), five documentation recommendations for 2SLGBTQIA+ clients emerged. Each will be followed by a rationale and supporting evidence from the existing literature. It is acknowledged that I have no authority over regulatory bodies, so my advice is nonprescriptive. Rather, I invite therapists to consider using and adapting these suggestions in order to work in close alliance to their existing standards. However, it is also relevant to note that the following recommendations are, to my knowledge, the first of their kind.

## 5.1 Recommendation 1: Codevelop a Plan With the Client for GI- and SO-Referential Language Prior to Documenting This Information

Therapists should broach outing concerns relating to "confidentiality and documentation issues" (Boroughs et al., 2015, p. 157) as soon as possible with their new clients. This recommendation thus entails communicating to the client their right to NOT provide GI or SO information on intake forms. Furthermore, with TGD clients, Perry and Green (2017) argued that early conversations should explicate which name and pronouns to use in counselling, whether the client is out, and "with whom [they] prefer not to share [their GI information]" (p. 22), the last of which may then be placed at the beginning of the client's file to ensure all staff comply with these wishes. Similarly, the authors advised seeking client consent to disclose their GI before referring them to other service providers with whom this information would be shared.

One cannot assume that clients permit to disclosing their SO or GI with all inside the circle of care just because they have shared this information with their counsellor (Canadian Public Health Association & Canadian HIV/AIDS Legal Network, 2017). Privacy needs are subjective. However, it will be important to explain the rationale for this process to the client, as lack thereof may cause them to question the psychologist's motives or belief in their self-referential GI. Therapists are also advised to take great care in specifying and compensating for communal documentation systems wherein the sharing of client information is beyond their control (e.g., interagency electronic health record databases).

## 5.2 Recommendation 2: Document SO- Or GI-Referential Information in Session Notes if and only if Germane and Consented to

Counsellors are advised to take great care in determining whether the client's GI or SO is the basis for the presenting problem (Boroughs et al., 2015). If not, it is worth asking whether this data is necessary to enter into session notes at all, and they must first identify whether they even have the client's consent to do so. For instance, therapists should consider how documenting references to top surgery, gender dysphoria, or same-gender partners may signal SO or GI, eliminating these instances wherever they are not absolutely required. Thus,

creating and maintaining session notes is for the client's benefit (CPA, 2017a): Primarily, their purpose is to "enhance the [therapeutic] process by helping the counselor track the client's progress while focusing on the treatment plan (Hutchinson et al., 2008, p. 51). Thus, when creating documents for 2SLGBTQIA+ clients, striving for minimally detailed progress- or change-focussed notes is strongly advised (Hodson & McBride, 2022).

Adhering to this recommendation may benefit the client, but it also means therapists may need to deviate from expected protocols. In the case that leaders from their organization or regulatory body question the lack of detail in their session notes, therapists may need to justify their vague disclosure in their charts, and they must present their case while respecting the confidentiality of the client's GI or SO. Additionally, strict reliance on progress notes may prove more complicated for counsellors with a psychodynamic orientation (Mills, 2014).

## 5.3 Recommendation 3: Utilize Affirming Language as Much as Possible Where Safe and Appropriate to Do So

If clients are not concerned by the disclosure of their GI or SO, it is considered best practice to mirror their terminology (Perry & Green, 2017) in all instances. Adhering to this recommendation requires the use of culturally situated language (Coleman et al., 2022), such as documenting the term '2-Spirit' instead of 'nonbinary' for First Nations, Metis, or Indigenous clients who prefer this GI label. Furthermore, counsellors should also consider communicating their willingness to update the client's GI or SO in their file as much as the latter wants or needs (Potter, 2020) to ensure the consistent use of affirming language. However, a more complex plan may be needed if clients are concerned about public knowledge of their GI or SO (e.g., if entered into their files or stated verbally in a public setting like the waiting room). In this case, psychologists might verbally utilize affirming terms in sessions while erring on the side of caution in their session notes (e.g., using gender neutral language; see Recommendation 4).

It is considered best practice to utilize 2SLGBTQIA+ affirming language (APA, 2021; Coleman et al., 2022). This language communicates one’s acceptance of and respect for the client’s SO or GI, and some have argued that, for TGD individuals, it may attenuate depressive and gender dysphoria symptoms and suicidality (Coleman et al., 2022; Russell et al., 2018). In sum, the use of these validating terms seems to support both client dignity and 2SLGBTQIA+ cultural competence.

However, particular caution may be required when therapists cannot use affirming language beyond the verbal communications during sessions (e.g., in session notes or consultations). Namely, when one becomes accustomed to using this language, they may slip up, accidentally writing or stating terms indicating the client’s GI or SO. This accidental outing may be especially troublesome if it is recorded in the client’s file, since this information will become available for a number of providers for the duration of the file’s existence.

## 5.4 Recommendation 4: Consider Using Neutral or Unmarked Client Descriptors When Creating Session Notes

Where concerns of indicating GI or SO exist, it may be safer to use neutral or less descriptive language to limit indications of these client characteristics in their session notes. For TGD individuals, this may include using “the client” or epicene third-person singular pronouns (i.e., they/them/theirs) in lieu of gendered pronouns or names. This suggestion may be especially important for clients who use neopronouns (e.g., e.g., ve/vir/vis), since these terms are clear demarcations of TGD identity. Additionally, instead of using phrases like ‘preferred name’, ‘chosen pronouns’, or ‘transgender woman’, or ‘queer couple’, it may be a better preferable to remove the preceding adjective, replacing the previous examples with simply ‘name’, ‘pronouns’, ‘woman’, and ‘couple’, respectively. Using more general terms in lieu of their more GI- or SO-specific equivalents (e.g., ‘clothing’ instead of ‘dress’) may serve a similar function.

The shift towards more ambiguous language may reduce indicators of client GI or SO in their files. However, decreasing the use of prefixes, descriptors, and word choices also has the benefit of rejecting the demographic labels typically only applied to 2SLGBTQIA+ individuals, thereby validating the authenticity and normality of the client’s GI or SO. This practice limits verbal othering, which upholds the “unmarked nature of the cis subject” whereas “trans people are always trans people, never people full stop” (Ashley, 2021, p. 428) under this language.

Nonetheless, it is important to note that some clients may prefer the use of demographic labels specific to 2SLGBTQIA+ individuals. Additionally, introducing gender neutral terms into session notes without the consent of TGD clients constitutes misgendering. Thus, in both of these cases, it is imperative to consult with clients prior to using such record keeping practice.

## 5.5 Recommendation 5: Use Open Notes and Shared Decision-Making

To ameliorate outing risks, one might regard the management of charting as relational, a shared endeavour (Hodson & McBride, 2022). This makes a case for *open notes*, or the practice of full transparency and joint authorship of session notes (Schwarz et al., 2021). With 2SLGBTQIA+ clients, psychologists may “ask for, receive, give, and use feedback” (Barstow, 2021, Definitions section) on their authorship style and when making record keeping decisions. Similarly, when new factors impacting GI or SO confidentiality are introduced, client consultation offers an avenue to determine whether existing protectionary measures are sufficient.

Engaging the client as an expert and collaborator are indispensable for reifying aspirational and relational ethics in recordkeeping. Not only do these methods allow the client to correct errors entered into the record, but they also have the potential to limit the power differential, increase the client's trust in their counsellor, and enhance the co-construction of the therapeutic process (Bemister & Dobson, 2011). 2SLGBTQIA+ clients are the only experts of their own life, and as such they possibly have the greatest capacity to make functional charting decisions with regard to their confidentiality needs (Perry & Green, 2017). Despite their best intentions, the outcome of clinicians' behaviours often differs from their intent (Barstow, 2021). This means that, if after presenting the possible outing risks, the client enthusiastically consents to the disclosure of their GI or SO in their record, psychologists should mirror the client's language, instead of paternalistically assuming that they are unable to fully understand the risks.

However, several warning should be considered. The use of these methods is incumbent on ensuring full client comprehension of the documentation outing risks. It is also worth noting that some scholars have asserted that open notes may solicit therapeutic rupture or the client's doubt in the counsellor's competence or trustworthiness (Mills, 2014). Bemister and Dobson (2012), however, refuted this notion, and recent evidence has cited the benefits of shared decision-making in healthcare outcomes (Nieder et al., 2020).

## 5.6 Chapter Summary

Primarily, the intent of this chapter was to supply charting recommendations specific to 2SLGBTQIA+ clients. Each suggestion was accompanied by an explanation of potential methods as well as a description of benefits and limitations. Chapter 6 synthesizes the material presented thus far and offers a novel modification of the CPA's (2017b) ethical decision-making model to assist with moral dilemmas involving this demographic. To conclude this project, I will describe its strengths and limitations as well as areas of future research.

# CHAPTER 6: SYNTHESIS AND CONCLUSION

In this last chapter, I will present the implications of this project to inspire counselling psychologists to implement creativity and connectedness when translating aspirational maxims into their actual conduct. A discussion of the project's value and limitations will follow. The final section will provide recommendations and potential future areas of research to propagate this line of inquiry within the scholarly community.

Underlying this Master of Counselling project were three ethically driven aims: 1) highlight the confidentiality risks for closeted 2SLGBTQIA+ clients; 2) showcase the value of ethical decision-making when exploring these risks; and 3) advocate for recordkeeping competence, particularly as it relates to protecting the privacy of 2SLGBTQIA+ clients. Notably, these aims were met by the authorship of five chapters that dove deep into analyzing the limited available literature complete with a case study. When developing this work, it became very clear to me that the ethical literature, including psychologist regulations, do not have the capacity to adequately advise conduct for the entire scope of subdisciplines or diverse clients (Pettifor, 2009; Pope, 2015). To me, this implies that the existing guidelines do not seem to sufficiently accommodate people or challenges beyond the 'norm', such as the foci of this analysis: 2SLGBTQIA+ clients. I spent considerable time in this project analyzing the apparitions of systemic power (APA, 2021; Herriot & Knight, 2023; Ward, 2017) that appear to be rooted in hegemony and created by straight, cisgender policymakers with the intent of promoting much needed growth within the field.

To help navigate this complex injustice to 2SLGBTQIA+ clients, I utilized an ethical decision-making process in which I had received training. However, one of the weaknesses in this analysis was the absence of client consultation in the resolution process for the case study. I believe soliciting client input is necessary to ensure adequate cognizance of clinician biases and the needs and preferences specific to each client, in the pursuit of cultural competence and social justice foci (Ashley, 2021; Baiocco et al., 2022; Calder, 2022).

## 6.1 Ethical Decision-Making Model for 2SLGBTQIA+ Clients

I would like to see an expansion of the CPA's decision-making approach that increases attention to intrapersonal or interpersonal components, as is suggested in the feminist decision-making model [Hill et al., 1998] and the Standards of Care for the Health of TGD People [Coleman et al., 2022]). Therefore, I have provided some recommendations for modifying the CPA's ethical decision-making model to help future users of this framework become more sensitive and attuned to the needs of 2SLGBTQIA+ clients by increasing the expansiveness of their analysis (see Table 9).

Table 9
*Modified Ethical Decision-Making Model for 2SLGBTQIA+ Clients*

| **Canadian Psychological Association's Ethical Decision-Making Framework (2017b)** | **Complementary Steps and Considerations for 2SLGBTQIA+ Individuals** |
|---|---|
| 1. Identification of the individuals and groups potentially affected by the decision. | Identification of how the decision may impact 2SLGBTQIA+ clients and social justice in general. |
| 2. Identification of ethically relevant issues and practices, including the moral rights, values, wellbeing, best interests, and any other relevant characteristics of the individuals and groups involved, as well as the cultural, social, historical, economic, institutional, legal or political context or other circumstances in which the ethical problem arose. | Consideration of the biases and philosophical orientation of ethico-legal regulations and tools, including organizational policies and the ethical decision-making model itself, as well those of general society and the consultant. |

| **Canadian Psychological Association’s Ethical Decision-Making Framework (2017b)** | **Complementary Steps and Considerations for 2SLGBTQIA+ Individuals** |
|---|---|
| *Opportunity for consultation with the client and knowledgeable professionals.* | |
| 3. Consideration of how one’s own biases, external pressures, personal needs, self-interest, or cultural, social, historical, economic, institutional, legal, or political context and background, might influence the development of or choice between courses of action. | Attention to the following areas to identify personal biases and reactions related to 2SLGBTQIA+ clients: one’s own positionality in terms of personal gender identity, sexual orientation, and role expectations related to these characteristics; intuition regarding preferred methods of resolution; and embodied experiences to identify emotional responses to the conflict and the client. |
| 4. Development of alternative courses of action. | Consideration of subjectivity and context (e.g., identifying how one’s supervisor, a community- or hospital-based psychologist, or the client might identify any additional courses of action). |
| 5. Analysis of likely short-term, ongoing, and long-term risks and benefits of each course of action on the individuals and groups involved or likely to be affected, taking into account relevant individual and cultural, social, historical, economic, institutional, legal, and political contextual factors. | Identification of 2SLGBTQIA+-specific threats (e.g., outing risks, pathologizing of SO and GI in the field, cisheterosexist loved ones, etc.). |
| *Opportunity for consultation with the client and knowledgeable professionals*. | |
| 6. Choice of course of action after conscientious application of existing principles, values, and standards (which includes but would not be limited to relevant laws and regulations). | Consider how one’s values and desire to adhere to the “norm” might influence course of action (e.g., self-protective actions due to fears of financial, professional, or status loss). |
| 7. Action, with a commitment to assume responsibility for the consequences of the action. | Evaluation of whether one is prepared to accept the consequences of rejecting mainstream societal and professional norms for the identified benefits associated with the selected course of action (e.g., reprimand from agency leaders). |

| **Canadian Psychological Association's Ethical Decision-Making Framework (2017b)** | **Complementary Steps and Considerations for 2SLGBTQIA+ Individuals** |
|---|---|
| *Opportunity for consultation with the client and knowledgeable professionals.* | |
| 8. Evaluation of the results of the course of action. | Ongoing client consultation to identify the impact of the decision on the micro- and macrosystems (e.g., ruptures to personal relationships, the rejection of cultural values, or congruence with equity-seeking aims). |
| 9. Assumption of responsibility for consequences of action, including correction of negative consequences, if any, or re-engaging in the decision-making process if the ethical issue is not resolved. | Implementation of shared decision making where appropriate in determining what remediation is required and how the plan may need to change in response to dynamic situational demands. |
| 10. Appropriate action, as warranted and feasible, to prevent future occurrences of the dilemma. | Remediation efforts for extant personal cisheterosexist attitudes and those existing in the norms of the field. |

## 6.2 Value of the Literature Review and Manuscript

As this project demonstrated, effective documentation practices with 2SLGBTQIA+ clients necessitate exceptionally clear consent processes with regard to the limits to privacy, as well as record keeping practices that embody equity and the right use of power (Barstow, 2021). The work completed for this project thus marks an important initiative in the progression of ethical counselling practices for 2SLGBTQIA+ clients.

One, it represents a small yet important step towards remediating the void of recent literature on recordkeeping within the Canadian climate and the formation of socially just equipoise for TGD clients within this context. It also facilitates the construction of practical guidelines for culturally and socially responsive approaches to ethical duties. Despite the foci of this project, its aspirational quintessence may also be extrapolated to serve clients with other stigmatized characteristics or concerns—such as those involved in plural marriages or with positive HIV statuses—even individuals served by helping professions in other fields (e.g., social work) or beyond Canadian border.

Second, the provision of an ethical decision-making case study applying the CPA's model (2017a) is also relatively novel. There appears to be few exemplars that specifically apply this framework. In fact, besides the examples in its *Companion Manual* (2017b) and those provided in this writer's counsellor education program (e.g., McBride, 2022), I could only locate one ethical decision-making case study using this framework (i.e., Hodson, 2022). Furthermore, this case study is unique in that it presents the application of a modified form of the CPA's ethical decision-making model designed to accommodate the specific demands of this subset of practice and clientele, something which, to this author's knowledge, seems to be the first of its kind.

Finally, the body of the project advocates against conditions within the current field that contribute to social injustice for 2SLGBTQIA+ clients, simultaneously offering an emerging resource to aid in equity-seeking efforts. These actions approach the fulfillment of *the Code's* (CPA, 2017a) final aspirational principle: responsibility to society.

### 6.3 Cautions

Several warnings are provided for the readers of this project. For example, the paucity of empirical research directly explicating the phenomena underlying psychological charting, ethical decision-making, and the issue of outing in this context, a definite or evidence-based claim of the theorized benefits is not possible at this time. Furthermore, due to this project's emphasis on the CPA's model and the Canadian field, these findings are specific to the nuances of this sociocultural and professional context. Differences in the capacity to apply this approach also exist between traditions within the subdiscipline of therapy itself, as certain subsets have specialized charting requisites that may not align with the recommendations described in this paper (e.g., psychoanalysts tend to require detailed process-focused notes; Mills, 2014).

Caution also needs to be shown around the interpretations made in this project given the subjective nature of my comments and reflections. The first and most critical concern is obvious: as a cisgender woman, I have no first-hand experience of being TGD. This ties into my earlier concern that the clients' voice is lacking in this project, and future research efforts will need to centralize TGD voices and leadership in the development of projects.

I also wish to alert readers to another consideration of my work: It is important to remain attentive to the diversity of 2SLGBTQIA+ clients (APA, 2021). It is vital that readers do not make assumptions of any sort, including homogeneity, when considering the applicability of this project for their practice (Teo, 2009, 2010, 2015). According to Ward (2017), inaccurate interpretations of group-based research can engender prejudice when:

> …. additional knowledges or explanations about groups of people that are ignored or overlooked (Teo, 2009), and interpretations/conclusions about groups of people are misunderstood and misrepresented (p. 133).

For example, universally applying gender-blind assumptions or standardized charting practices that lump all TGD clients into one group is inappropriate. These individuals have differing privacy needs and expectations surrounding the protection of this right in psychological record keeping.

## 6.4 Areas of Future Research

Two themes identified by Baiocco et al. (2022) seem to be at the forefront of research needs that I have related to this project: 1) enhancing the inclusivity and robustness of studied demographics and their care as it relates to ethical care (specifically consent, ethical decision making, and note taking), and 2) attenuating “biases and stereotypes in health and social care professionals” as it relates to the forementioned areas. Given the lack of literature on charting and ethical decision-making, the potential for future scholarship in these areas are vast. Significant opportunities also exist for research surrounding TGD people, as the literature is in its infancy and largely tends to focus on sexual health and gender-affirming medical care (Coleman et al., 2022). Current researchers have argued that, in general, investigations surrounding 2SLGBTQIA+ individuals require an intersectional lens (Burgwal et al., 2019) and more TGD-led projects are needed, including in the arena of policy reform (Herriot & Knight, 2023). I hope that future research on ethical needs of 2SLGBTQIA+ individuals are separated not only by SO and GI, but also by their subgroups (e.g., asexual versus polysexual for SO and 2-Spirit versus nonbinary for GI; Cameron & Stinson, 2022; Roemer, 2023).

Another potential focus is undertaking a mixed-methods study to explore the relationship between estimated and actual levels of implicit attitudes and prevalence of bias-laden or unethical terminology in client documentation, which could be explored through the use of semi-structured interviews, the Implicit Association Test (for measure specific to perceptions of trans individuals, see Axt et al., 2021), and thematic analysis, respectively. This type of research would also help unpack the importance of Step 3 in the CPA’s decision-making process. Perhaps, even an investigation of psychologists’ ability to undertake a scrupulous introspective analysis for Step 3 would benefit the field, as this project has consistently stressed that psychologists need to be aware of their biases, so it is worth identifying their needs and challenges associated with achieving said task.

Future research might similarly explore the phenomenology of applying the CPA's decision-making model. Investigators could also analyze the efficacy of its modified frameworks, like that presented in this project (see Table 9), by comparing these experiences or reasoning outcomes to those obtained from the CPA's methods.

In spite of this call for research, I argue that the need for practical tools, including supports for ethical decision-making, charting, and confidentiality conducive language, may be even more important for therapists. There is a need to explicate how to increase counsellor education on topics pertaining to the clinical and ethical aspects of care for 2SLGBTQIA+ clients (particularly TGD people; Coleman et al., 2022) such as charting and ethical decision-making for stigmatized topics. Previous research has identified the paucity of provider training in these topics, yet there remains little literature explicating the specific effects of these deficits or how to best remediate their effects at the practitioner- and educational-levels (McDowell & Bower, 2016).

In surmounting the aforementioned issues, researchers and field leaders should also consider developing supplemental practice guidelines to augment the CPA's generalist framework (2017a). Such suggestions for TGD people already exist in the United States (e.g., APA, 2015), while similar guidelines specific to Canadian psychology have been developed for community psychologists (Pettifor, 2009) and those working with women and diverse clients (CPA, 2017b).

## 6.5 Conclusion

This project is a treatise whose intention is to help restore the personal power of 2SLGBTQIA+ individuals by addressing their therapist's record keeping practices. My intention, however, is not to focus on the hardships and perils of this community; instead, its scope represents an impetus to reflect on the rights and capabilities of 2SLGBTQIA+ clients as leaders in decision-making to establish conceptual equipoise. Not only does this encourage clinicians to act in ways protective of 2SLGBTQIA+ people's moral rights, but it also nudges corresponding societal discourse towards a strengths-based inflection. It is worth asking what we could achieve if we focused on the care, advocacy, and autonomy of 2SLGBTQIA+ people instead of focussing solely on their hardships (Calder, 2022). Addressing cisheterosexist injustices—such as queerphobia and trans misogyny—requires a genuine concern for 2SLGBTQIA+ people and a desire to restore their equity. Without this, I fear that claims of advocacy may become tantamount to little more than lip service, co-opted for the benefit of existing hegemonic power. When working with 2SLGBTQIA+ counselling clients, social justice efforts must therefore always be present; hence, this project.

Despite my concerns noted in this project, I do not wish to dispel *the Code* (CPA, 2017a), but rather I argue in favour of an approach that acknowledges its benefits whilst considering its philosophical orientation in a way that accommodates its application for those who do not necessarily land within its margins. I believe my project makes an important step in this direction by offering an analysis of the limitations to record keeping practices when working with those who must remain closeted until they choose to reveal this information.

In conclusion, the question for counselling psychologists is not which strides have been made in the domain of human rights and equity, but rather which parties are still left behind (Namaste & Tourki, 2020)? This query is reminiscent of aspirational ethical aims. For this profession to truly honour its responsibility to society, I believe each therapist must strive to induce social justice by means of personal and disciplinary change—aims which parallel the function of this project. Namely, I hope to start my counselling career by supporting the development of ethical competence around consent and charting processes for 2SLGBTQIA+ clients. I recognize that there are countless steps remaining in this arduous endeavour, but this project is one small contribution towards surmounting outing issues in record keeping, so 2SLGBTQIA+ counselling clients can feel safe in their therapists' offices.

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# APPENDIX 1: DON'T LET THE CAT OUT OF THE BAG: RECORD KEEPING ISSUES WITH 2SLGBTQIA+ CLIENTS

## PREAMBLE

### Purpose

The following is the applied element of the Master of Counselling project. It is a draft manuscript for Canadian Psychology / Revue Canadienne (https://www.apa.org/pubs/journals/cap), which will be submitted to the journal editor by June 30, 2024, or after the University of Lethbridge has approved the project. The first author of the article will be Sydney Gelineau-Olay, and the second author will be my project supervisor, Dawn McBride[1].

The purpose of this manuscript is to contribute a valuable resource to an area of psychology that lacks literature and research. This manuscript will explore the ethical issues associated with record keeping for 2SLGBTQIA+ counselling psychology clients and the implications of emic approaches to decision-making and other ethical duties.

### Journal's Instructions for Authors

Appendix 2 provides the submission guidelines Canadian Psychology / Revue Canadienne. Additionally, because the authors of this manuscript intend to submit to a special edition, specific criteria for this publication are also included.

### Format Style Requirements

This manuscript complies with the Publication Manual of the American Psychological Association, 7th Edition (2020), per the criteria provided by Canadian Psychology / Revue Canadienne.

### Copyright Statement

The material included in this draft manuscript is subject to copyright, and permission of the author or the author's supervisor (Professor Dawn McBride) should be sought prior to use. For permission, please email the author's supervisor at dawn.mcbride@uleth.ca. The reader may use ideas from this project and draft manuscript providing they are referenced as follows:

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[1] This preamble closely followed the format and structure of *The dual role of psychologist-researcher: Using psychological assessments for research purposes* [Unpublished master's project], by E. Kewley, 2013: University of Lethbridge. Copyright 2013 by E. Kewley.

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# Abstract

This paper critically examines the privacy and confidentiality implications of Canadian psychology regulations for closeted 2SLGBTQIA+ clients. Whenever possible, a detailed analysis of empirical, ethical, and legal literature was used to inform this inquiry. Given the void of research on record keeping practices and ethics for this demographic, a fictionalized case study is provided as a supplementary measure exemplifying considerations for practice and the application of a novel decision-making framework for diverse clients modified from that of the Canadian Psychological Association (2017a). The final contribution of this article is a series of practice recommendations for charting with 2SLGBTQIA+ clients in a manner that strives for efficacy, ethicality, and social justice.

**Key Words**: record keeping, 2SLGBTQIA+, confidentiality, ethics, social justice

**Public Significance Statement**: This study suggests that when practicing with 2-spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual, plus clients, increased attention to client collaboration, social justice, context, and subjectivity may enhance the efficacy and ethicality of efforts to protect the confidentiality of sexual orientations and gender identities that have not been disclosed beyond the therapeutic space. Particular attention is given to psychological documentation and shared decision-making.

# Don’t Let the Cat Out of the Bag: Record Keeping Issues With 2SLGBTQIA+ Clients

The purpose of this paper is to examine the potential hazards associated with an overreliance on the Canadian Psychological Association’s (CPA) ethical guidelines for documentation when writing session notes for 2-spirit, lesbian, gay, bisexual, transgender, intersex, asexual, plus (2SLGBTQIA+) counselling clients. Given the lack of privilege in Canada, clients' moral rights to privacy and confidentiality are under threat (Bradford & Stevens, 2013; Mills, 2014), particularly for those who are not ready or able to reveal their gender identity (GI) or sexual orientation (SO) beyond the therapeutic environment. For instance, session notes may inadvertently expose the client’s hidden SO or GI to outside parties (Boroughs et al., 2015), an error known as *outing*.

To begin, this paper will confirm the absence of privileged communications in counselling records, followed a discussion surrounding the importance of exceptionally careful notetaking practices for therapists practicing with 2SLGBTQIA+ clients who are not public with their GI or SO (i.e., *closeted*). Thereafter, it will identify the factors implicated in this ethical issue before providing a rationale for the proposed expansion of the CPA’s decision-making framework for 2SLGBTQIA+ clients. This novel framework will be applied to a fictional case study to demonstrate its relevance. From this analysis, a series of practical recommendations will be supplied to assist counselling psychologists in their record keeping duties with 2SLGBTQIA+ clients. Closing the paper is a description of its limitations and a conclusion.

## Record Keeping Challenges for Closeted Clients

Counselling session notes are nonprivileged communications thereby potentially making them accessible to those beyond the counselling alliance (Hadskis, 2018), even in the absence of client consent (Mills, 2014). This poses serious privacy risks for 2SLGBTQIA+ clients who have records where counsellors have alluded to their concealed GI or SO (e.g., gender dysphoric symptoms, pronouns associated with the client’s closeted GI, or the indication of a same-gender partner).

### *Implications of Outing*

Unpermitted disclosures can produce ruinous consequences for closeted individuals. These perils directly stem from and reinforce *cisheterosexism* (Community-Based Research Centre, 2021): the “societal and institutional privileging of heterosexuality, cisgender identity, and binary sex assignment as [a required, desirable, and natural] norm” (The University of North Carolina-Chapel Hill LGBTQ Center, n.d., para. 4). Outing constitutes “psychological violence” (Drescher & Fadus, 2020, p. 264) that can thrust the alliance into disrepair, dissuade the client from pursuing future services (*R v Mills*, 1999), and may even create serious risks for the client. Therefore, the disclosure of GI or SO in session notes could pose a significant risk to the closeted individual’s safety, relationships, and wellbeing if the client’s files are disseminated to those with prejudiced views.

### *Aggravating Factors*

The prospect of outing clients via their clinical records is especially concerning in the context of extant cisheterosexist attitudes, mistreatment, and charting fallacies of helping professionals (Coleman et al., 2022; Lau et al., 2020; Nieder et al., 2020). This last issue has been documented in the literature (e.g., Lau et al., 2020; Thompson, 2016) in such forms as sharing the client's GI or SO information through the unauthorized distribution of their files and misgendering related to under- or overdocumentation. Recognizing contributing factors may be helpful in understanding why these issues occur in the first place.

**Lack of Resources and Preparedness.** The lack of existing resources on record keeping poses a significant threat to the ethical capacities of psychologists. There is a paucity of literature on psychological charting and ethical decision-making (Johnson et al., 2022), let alone that specific to 2SLGBTQIA+ clients (Nadler et al., 2021) and the Canadian context (Bradford & Stevens, 2013; Mills, 2014), meaning therapists have little in the way of evidence-based guidance. Research suggests that the feelings of confusion and ill-preparedness are prevalent among providers when it comes to protecting confidentiality and determining how much stigmatized data to record (Chivilgina et al., 2022; Kilty & Orsini, 2019), a phenomenon that also appears to apply to documentation practices with 2SLGBTQIA+ clients (Nadler et al., 2021). Psychologists' fear exacerbates their uncertainty by skewing their charting practices towards rule-based ethics, status quo conduct, or "defensive record keeping" (Pope, 2015, p. 354), which may be particularly problematic given the highly subjective privacy needs of 2SLGBTQIA+ individuals with undisclosed GIs or SOs.

**Ideologies of Ethical Guidelines.** Given the lack of privilege for clients and their counsellors, ethical resources need to be consulted to impart the guidance necessary to mitigate outing threats. Current ethico-legal tools and regulations often represent artifacts of society that replicate its hegemonies and the values of those in power (Herriot & Knight, 2023; Walsh, 2015; Ward, 2017). Thus, biases like cisheterosexism may seep into ethical reasoning as a result. For example, in the *Canadian Code of Ethics for Psychologists* (hereon referred to as *the Code*; CPA, 2017a) there is no mention of how to document stigmatized topics, or how to approach ethics from a culturally responsive lens for 2SLGBTQIA+ clients.

One of the strengths of *the Code* is its emphasis on social justice, which is a requisite for 2SLGBTQIA+ cultural responsivity (Baiocco et al., 2022). Yet, in one study, a sample of transgender and gender diverse (TGD) patients reported experiences wherein their gender identity (GI) "was involuntarily disclosed, misinterpreted or abused, and their safety and care was compromised" (Lau et al., 2020, p. 1779), thus indicating that the relationship between provider incompetence in cultural and socially just aspects of care can be reciprocal and detrimental. This paper will offer several recommendations to help resolve the ethical dilemma psychologists may face when deciding when or if they will record their client's GI.

## Expanding the CPA's Ethical Decision-Making Steps

When working with closeted clients and in an ethical dilemma regarding their charting of pronouns, it may be necessary to expand Step 3 (reflection) and Step 4 (alternatives) of *the Code's* decision-making framework to increase one's attention to context and diversity (du Preez & Goedeke, 2013; Walsh, 2015; Ward, 2017). The aim in presenting these recommendations is to reduce the power differential (Barstow, 2021) and promote opportunities for equity-seeking collaboration (Goldenberg, 2015; Young & Kenny, 2022). Though seeking expert advice is recommended, the CPA (2017a) does not suggest client consultation outside of research, nor does it mandate any interpersonal contact (Johnson et al., 2022). However, when the situation involves marginalization, safety concerns, or personal differences within the therapeutic alliance (Young & Kenny, 2022), we believe client participation may serve to attenuate the impacts of biases and centralize the client's interests and perspectives when making record keeping decisions.

The overarching goal is to resolve an ethical dilemma that involves a client in a way that aligns with the client's values or needs, without depending solely on the psychologist's perceptions. To showcase the value of expanding upon the CPA's framework to include the client's voice and increase the social justice element, the next section introduces a vignette taken directly from Gelineau-Olay (2023) that depicts a modified ethical decision-making process related to outing risks in record keeping. Of note is that the analysis depicts only the primary considerations identified by the authors, as a more detailed review is beyond the scope of this paper. Due to space constraints, the CPA's steps and standards (reproduced from 2017b and 2017a, respectively) were also truncated in a manner that maintains fidelity to the original texts.

Before presenting the dilemma, a proposed modification to the decision-making process is offered in response to the call for emic and socioculturally cognizant reasoning for 2SLGBTQIA+ individuals. These recommendations were drawn from relevant literature like the feminist decision-making model (Hill et al., 1998) and *the Standards of Care for the Health of TGD People* (Coleman et al., 2022). The framework (see Table 1; modified from Gelineau-Olay, 2023) will be applied in the following section to simulate a resolution process.

Table 1
*Modified Ethical Decision-Making Model for 2SLGBTQIA+ Clients*

| **Canadian Psychological Association's Ethical Decision-Making Framework (2017b)** | **Complementary Steps and Considerations for 2SLGBTQIA+ Individuals** |
|---|---|
| 1. Identification of the individuals and groups potentially affected by the decision. | Identification of how the decision may impact 2SLGBTQIA+ clients and social justice in general. |
| 2. Identification of ethically relevant issues and practices, including the moral rights, values, wellbeing, best interests, and any other relevant characteristics of | Consideration of the biases and philosophical orientation of ethico-legal regulations and tools, including organizational policies and the ethical |

| **Canadian Psychological Association's Ethical Decision-Making Framework (2017b)** | **Complementary Steps and Considerations for 2SLGBTQIA+ Individuals** |
|---|---|
| the individuals and groups involved, as well as the cultural, social, historical, economic, institutional, legal or political context or other circumstances in which the ethical problem arose. | decision-making model itself, as well those of general society and the consultant. |
| *Opportunity for consultation with the client and knowledgeable professionals.* | |
| 3. Consideration of how one's own biases, external pressures, personal needs, self-interest, or cultural, social, historical, economic, institutional, legal, or political context and background, might influence the development of or choice between courses of action. | Attention to the following areas to identify personal biases and reactions related to 2SLGBTQIA+ clients: one's own positionality in terms of personal gender identity, sexual orientation, and role expectations related to these characteristics; intuition regarding preferred methods of resolution; and embodied experiences to identify emotional responses to the conflict and the client. |
| 4. Development of alternative courses of action. | Consideration of subjectivity and context (e.g., identifying how one's supervisor, a community- or hospital-based psychologist, or the client might identify any additional courses of action). |
| 5. Analysis of likely short-term, ongoing, and long-term risks and benefits of each course of action on the individuals and groups involved or likely to be affected, taking into account relevant individual and cultural, social, historical, economic, institutional, legal, and political contextual factors. | Identification of 2SLGBTQIA+-specific threats (e.g., outing risks, pathologizing of SO and GI in the field, cisheterosexist loved ones, etc.). |
| *Opportunity for consultation with the client and knowledgeable professionals.* | |
| 6. Choice of course of action after conscientious application of existing principles, values, and standards (which | Consider how one's values and desire to adhere to the "norm" might influence course of action (e.g., self-protective |

| **Canadian Psychological Association's Ethical Decision-Making Framework (2017b)** | **Complementary Steps and Considerations for 2SLGBTQIA+ Individuals** |
|---|---|
| includes but would not be limited to relevant laws and regulations). | actions due to fears of financial, professional, or status loss). |
| 7. Action, with a commitment to assume responsibility for the consequences of the action. | Evaluation of whether one is prepared to accept the consequences of rejecting mainstream societal and professional norms for the identified benefits associated with the selected course of action (e.g., reprimand from agency leaders). |
| *Opportunity for consultation with the client and knowledgeable professionals.* | |
| 8. Evaluation of the results of the course of action. | Ongoing client consultation to identify the impact of the decision on the micro- and macrosystems (e.g., ruptures to personal relationships, the rejection of cultural values, or congruence with equity-seeking aims). |
| 9. Assumption of responsibility for consequences of action, including correction of negative consequences, if any, or re-engaging in the decision-making process if the ethical issue is not resolved. | Implementation of shared decision making where appropriate in determining what remediation is required and how the plan may need to change in response to dynamic situational demands. |
| 10. Appropriate action, as warranted and feasible, to prevent future occurrences of the dilemma. | Remediation efforts for extant personal cisheterosexist attitudes and those existing in the norms of the field. |

## Analysis of a Fictional Case Study

Lumina is an Albertan counselling psychologist whose new client, Drew, is a self-referred 17-year-old student living on-campus for her first year of university. The client describes herself as a white, heterosexual, and middle-class transgender woman. Drew also states that she is seeking therapy is to address difficult experiences with cissexism and gender dysphoric symptoms, and she also shares her plans to seek a formal diagnosis of gender dysphoria sometime in the near future.

After the second session, Drew asks to discuss her experiences of being closeted to her parents and their favourable attitudes towards conversion therapy in the next counselling session. The client had not yet indicated any of this, instead stating that she was open regarding her GI and describing positive parent-child relationships. Thus, the therapist did not foresee this potential risk of outing.

Per agency policies, parental consent for treatment is not required for clients aged 16 and above, Lumina is aware that because Drew is a minor, her parents hold a legal right to access her records and terminate her treatment. Given the nature of the client's presenting issues, the intake form and session notes identified the GI foci of Drew's presenting issue. The therapist is concerned that the parents' awareness of Drew's records may encourage them to seek these documents and becomes worried about what would happen if they were to discover Drew's GI from her session notes. Lumina identifies she is in moral conflict and thus needs to engage in an ethical decision-making process.

### *The Ethical Dilemma*

If the client's parents exercise their legal right to seek access to their minor daughter's files, should the psychologist comply? To do so in the absence of client consent infringes on Drew's moral rights and may out her to her parents, thereby creating risks of harm for both the client and her parents.

Step 1: Identification of the Individuals and Groups Potentially Affected by the Decision.

- Primary: Drew (the client)
- Secondary: Lumina (the psychologist); Drew's parents and her other family member; Lumina's agency, supervisor, and colleagues
- Tertiary: TGD and 2SLGBTQIA+ counselling clients in general, current and future agency clients, public trust in the profession of psychology

Step 2: Identification of Ethically Relevant Issues and Practices.

Using *the Code* (CPA, 2017a) chart as a framework, 27 standards spanning all four principles appear to be pertinent to this dilemma: 12 standards under Respect for the Dignity of Persons and Peoples, eight under Responsible Caring, three under Integrity in Relationships, and four under Responsibility to Society (see Appendix 1). This section corresponds to the analysis provided by Gelineau-Olay (2023) and includes commentary adapted from this source. However, given the constraints of this paper, the subsequent analysis will be limited to only the most important considerations (see Table 2).

Table 2
*Overview of Applicable Values and Standards*

| Applicable Principle/Value/Standard | Pertinence of the Standard |
|---|---|
| **Principle 1: Respect for the Dignity of Persons and peoples** | |
| ***Value: General respect*** | |
| I.1 Demonstrate appropriate respect for the knowledge, insight, experience, areas of expertise, and cultural perspectives and values of others, including those that are different from their own, limited only by those that seriously contravene the ethical principles of this Code. | This standard appears to be pivotal to addressing the outing risks. In congruence with this standard, client consultation and shared decision-making offer means to identify the choice of action most in line with Drew's needs, autonomy, and equity within the alliance. |
| I.3 Strive to use language that conveys respect for the dignity of persons and peoples as much as possible in all spoken, written, electronic, or printed communication. | To respect TGD clients, gender affirming language is mandatory (Coleman et al., 2022). However, the counsellor and the client may need to negotiate which forms to use to in confidential verbal language versus visible forums (e.g., those documented or spoken in the office). |
| ***Value: General Rights*** | |
| I.8 Respect the moral right of research participants, primary clients, contract examinees, employees, supervisees, students, trainees, and others to safeguard their own dignity. | Coming out should be entirely the client's choice. Yet, this is a complicated matter for minors whose guardians hold the legal right to access their records. Therefore, limiting the transcription of potentially outing information is advised unless client consent is obtained. |
| ***Value: Informed Consent*** | |
| I.23: Provide, in obtaining consent, as much information as reasonable or prudent individuals and groups would want to know before making a decision or consenting to the activity. Typically, and as appropriate to the situation and context, this would include: purpose and nature of the activity; mutual responsibilities; whether a team or other collaborators are involved; privacy and confidentiality limitations, risks, and | This course of action appears to be central to the resolution of the dilemma. Because the client was not sufficiently informed of situations wherein the content of minors' psychological records is accessible (*Hopp v Lepp*, 1980), the consent is null. Therefore, at the next opportunity, the therapist must describe to Drew potential mechanisms for 3rd party access and their respective risks as well as the benefits and |

| Applicable Principle/Value/Standard | Pertinence of the Standard |
|---|---|
| protections;[and] likely risks and benefits of the activity, including any particular risks or benefits of the methods or communication modalities used. | risks of the psychologist’s notetaking style. |
| ***Value: Privacy*** | |
| I.39 Collect and record only that private information necessary for the provision of continuous, coordinated or collaborative service, or for the goals of the particular research study being conducted, or that is required or justified by law. | Because Drew’s presenting problem is directly related to her trans GI, this information is germane to her care and should thus be recorded, but this poses risks. Even if TGD GIs are not explicitly labelled in records, closeted clients with these identities may have their GI discovered if their name, pronouns, or other gendered information is discrepant to those by which they are known to the reader. |
| ***Value: Confidentiality*** | |
| I.45 Share confidential information with others only to the extent reasonably needed for the purpose of sharing, and only with the informed consent of those involved, or in a manner that the individuals and groups involved cannot be identified, except as required or justified by law, or in circumstances of possible imminent serious bodily harm. | The therapist cannot presume that the disclosure of client GI is permitted, even for agency staff or those within the circle of care. It should only be disclosed on a ‘need to know’ basis (Coleman et al., 2022; e.g., anonymizing the case information during consultation). It is also necessary to monitor situational factors and Drew’s safety (e.g., whether those seeking the file are aware and/or supportive of 2LSGBTQIA+ people) lest disseminating their GI or SO information exacerbates threats in this area. |
| ***Value: Extended Responsibility*** | |
| I.46: Encourage others, in a manner consistent with this Code, to respect the dignity of persons and peoples, and to expect respect for their own dignity. | Lumina may need to advocate for policy reform, including the development of agency measures that support clients’ right to self-determine whether to come out (e.g., gender-neutral terminology and client identification numbers in lieu of names to label session notes). |

| Applicable Principle/Value/Standard | Pertinence of the Standard |
|---|---|
| **Principle II: Responsible Caring** | |
| ***Value: General Caring*** | |
| II.10 Evaluate how their own experiences, attitudes, culture, beliefs, values, individual differences, specific training, external pressures, personal needs, and historical, economic, and political context might influence their interactions with and perceptions of others, and integrate this awareness into their efforts to benefit and not harm others. | Cisgender psychologists with little training in record keeping and/or supporting TGD clients must consider how these factors impede their ability to detect and remediate TGD-specific ethical issues in charting (also see II.14). |
| ***Value: Risk/benefit analysis*** | |
| II.14 Be sufficiently sensitive to and knowledgeable about individual and group characteristics, culture, and vulnerabilities to discern what will benefit and not harm the individuals and groups (e.g., couples, families, organizations, communities, peoples) involved in their activities. | The therapist documented copious indications of the client's GI due to a lack of knowledge surrounding outing risks. Albeit detrimental for any closeted individual, for this minor client, her age increases her vulnerability to outing hazards. |
| ***Value: Maximize benefit*** | |
| II.21 Create and maintain records relating to their activities that are sufficient to support continuity and coordination over time and to manage risks. | The essence of the current dilemma parallels these demands. Indicating that the client is trans is risky but also germane to counselling and should thus be documented (e.g., consistency in the use of gender affirming language and understandings of the client's challenges). |
| ***Value: Minimize harm*** | |
| II.32 Be acutely aware of the need for discretion in the recording and communication of information, in order that the information not be misinterpreted or misused to the detriment of others. This includes, but is not limited to … communicating information in language | To be explicit regarding the client's transfeminine GI is to increase outing threats and subsequent risks for the client harm. The psychologist may consider using indirect language to document germane information while circumventing explicit reference to the client's GI. Yet, these protective actions contravene this |

| Applicable Principle/Value/Standard | Pertinence of the Standard |
|---|---|
| that can be understood clearly by the recipient of the information. | standard. This directive thus conflicts with standard I.3, I.39, I.43, and II.21. |
| **Principle III: Integrity in Relationships** | |
| ***Value: Reliance on the discipline*** | |
| III.35: Seek consultation from colleagues and/or appropriate others, including advisory groups, and give due regard to their advice in arriving at a responsible decision, if faced with a difficult situation. | Collegial support is essential to the resolution of this conflict (Coleman et al., 2022; Hill et al., 1998), but client consultation and shared decision-making may be even more important to optimize the first principle and implement the most culturally responsive decision. |
| **Principle IV: Responsibility to Society** | |
| ***Value: Development of society*** | |
| IV.20 Be sensitive to the needs, current issues, and problems of society, when determining research questions to be asked, services to be developed, content to be taught, information to be collected, or appropriate interpretation of results or findings. | This standard is intended to dispel “the myth of a value free science” (CPA, 2017b, p. 123), but it is also pertinent to this dilemma in that sensitivity to cisheterosexism and outing may enhance the detection of ethical issues associated with universally applied expectations and procedures. |
| IV.21 If their work is related to societal issues, be especially careful to keep well informed of social, cultural, historical, economic, institutional, legal, and political context issues through relevant reading, peer consultation, and continuing education. | Because cisheterosexism is largely what makes outing dangerous, it is necessary to develop an awareness of one’s own biases and the sociocultural context and features of 2SLGBTQIA+ people. |
| IV.28 Speak out and/or act, in a manner consistent with the four principles of this Code, if the policies, practices, laws, or regulations of the social structure within which they work seriously ignore or contradict any of the principles of this Code. | Two facets of the sociocultural and ethico-legal climate require addressing: 1) the conflict between the call for equity versus societal cisheterosexism and power-over, autonomous decision making often found in therapy; and 2) how lack of privilege augments outing risks. |

At this stage, the psychologist should consider reviewing this analysis with the client and knowledgeable professionals. Through this contact, overlooked factors can be given the attention they deserve.

Step 3: Consideration of how one's own biases, external pressures, personal needs, self-interest, or cultural, social, historical, economic, institutional, legal, or political context and background, might influence the development of or choice between courses of action (CPA, 2017b).

Exploring positionality, intuition, emotional reactions, and embodied experiences may be of value, as Lumina notices herself trembling and sweating and feeling tightness in her chest when she imagines negative outcomes. The therapist believes that her trepidation relates to the prospect of conflicts surrounding identity politics due to her own experiences with discrimination and inequity. Nonetheless, she knows she is being presumptuous about the parents and acknowledges the need to bracket this while prioritizing Drew's interests. Lumina also recognizes that she has submitted to her agency's colonized consent process, despite her awareness that it was not relational (McBride, 2018), thereby indicating the presence of authority bias. To address these issues and confront her leaders regarding the agency's role in the dilemma (e.g., counselling minors in the absence of parental consent), she believes she must take action to reduce her fear of conflict and criticism.

As a cisgender woman, the psychologist failed to identify how GI and her lack of TGD-specific knowledge contributed to ignorance of Drew's precarious position. Other factors exacerbated this issue: limited training in notetaking and TGD care (e.g., the process of obtaining a medical transition), overestimations of her competence, and the belief in autonomy and self-determining GI without considering that the client may need to conceal this identity from 3rd parties by limiting this information in her session notes.

In addition, Lumina's concerns relate to her knowledge that TGD individuals, especially minors, are highly marginalized. Given the rampancy of cisheterosexism, Drew faces risks of discrimination and harm if her trans GI is discovered by prejudiced individuals, and Lumina is deeply concerned that the parents' awareness will encourage them to subject Drew to conversion therapy, an extremely harmful and illegal practice (An Act to amend the Criminal Code, 2021; CPA, 2023; United Nations Human Rights Council, 2020). Thus, ongoing monitoring and the protection of her safety and Lumina's TGD competence is required. Additionally, as adults, Lumina and the client's parents have more social and legal power than Drew, and though the therapist does not believe this is true in this case, the latter may have the right to access her records and govern her care. To compensate for these inequities requires the right use of power—including shared decision-making with the client.

Lumina's reasoning may also be influenced by professional norms and values. It is important to note that ethico-legal standards and tools have been created largely by and for those who have historically held power within society, meaning the views of queer and otherwise diverse individuals are minimally represented. The current guidelines embody Euro Western colonialist worldviews: rationality, objectivity, individualism, hierarchy (Clark, 2012; Fellner et al., 2020; Goldenberg, 2015; Walsh, 2015; Ward, 2017), and cisheteronormativity (Herriot & Knight, 2023). The omnipresence of these ideologies means they are often invisible and considered the only ‘right’ way to approach reasoning (Ward, 2017), despite their potential misalignment with the values of the general public (Gothjelpsen & Truscott, 2018; Seitz & O’Neill, 1996) and actual decision-making, the last of which may be far more rooted in diversity, context, relationships, and open dialogue than indicated by the Canadian field and guidelines (du Preez & Goedeke, 2013; Goldenberg, 2015; Levitt et al., 2015; Teo, 2009, 2010, 2015; Walsh, 2015; Williams, 2004). For this reason, psychologists creating charts for 2SLGBTQIA+ clients are advised to use relational methods to respond to subjective influences, including privacy needs and contextual factors, while increasing their attention to social justice and equity (Young & Kenny, 2022; Usher, 1997).

Step 4: Development of alternative courses of action regarding how to handle Drew’s file, if/when the parents request it.

There are several courses of action that the therapist considers. Regardless of the response chosen, the counsellor commits to the following: remaining attentive to the client’s subjectivity and contextual factors, seeking training in ethics with TGD clients and record keeping, obtaining professional support in determining a decision, and using relational session notes (McBride, 2018) to best determine the amount of GI detail to record.

**Alternative 1.** As permitted by her scope of authority (Bester et al., 2016; CPA, 2017a), Lumina will not alert Drew of the decision or what is in her file in hopes that no one requests these records until the client is ready to come out and takes action to do so.

**Alternative 2.** The therapist will close the file and open a new one, the latter of which would be provided if Drew’s parents request access. Lumina will not disclose her decision to the client to prevent distress.

**Alternative 3.** In their next meeting, Lumina will engage Drew in an exploration of the client’s impressions of her parents and their potential awareness of and reactions to her GI. This would be done in a manner that prevents the communication of the therapist’s apprehensions. Lumina will then describe her notetaking style and its depiction of relevant GI information, followed by an exploration of Drew’s reactions to its implication. If so desired, the client can be referred to those who can help her learn how to protect her records from 3rd party access.

Step 5. Analysis of likely short-term, ongoing, and long-term risks and benefits of each course of action on the individuals and groups involved or likely to be affected.

There is no perfect solution to this dilemma, but caution is crucial. Appraisals of the potential courses of action are summarized below (see Table 3), although Lumina recognizes that it is ideal to consult with the client or other experts in determining how to best proceed.

Table 3

*Possible Positive and Negative Consequences of the Potential Choices*

| Possible Positive Consequences | Possible Negative Consequences |
|---|---|
| **Alternative 1** | |
| Not disclosing the dilemma may prevent relational rupture, distress, and criticism. | Drew may be outed if her files are requested. |
| Managing this issue discreetly might prevent outing Drew's GI to 3rd parties. | The client's unawareness of these outing risks misaligns with the spirit of informed consent. |
| This option is quick and easy. | These actions do not help strive towards social justice or remediation in the profession. |
| **Alternative 2** | |
| The possibility of backlash, like negative client reactions and outing, may be avoided. | The therapist may be perceived to be hiding their missteps and Drew could still be outed. |
| If the 3rd parties do not request "all" records, then Drew's GI will remain confidential. | This choice reinforces inequities, undermines Drew's rights and informed consent, and may out her if she decides to share her records. |
| These autonomous actions avoid the potential challenges and messiness of trying to inform the minor client of complicated legal matters. | Lumina may be perceived to be hiding unethical conduct and thus may be penalized. |
| **Alternative 3** | |
| This option creates opportunities to continuously explore the changing situation and engage in shared decision-making to increase decisional fit with the client's perspectives. | If she becomes distressed, Drew may seek support from her parents or trusted adults, or she may disclose her counselling participation, and thus, they may seek her file. |
| Developing Drew's knowledge of her rights, confidentiality threats, and the | As a young trans person, Drew's cognitive level, limited legal knowledge, and the power differential may interfere with her |

| | |
|---|---|
| content of her records may enhance her ability to use her rights for self-protection.<br>This option promotes equity in their relationship. | comprehension and dissuade her objections.<br>This is the most time consuming, laborious, and complicated choice. |

Step 6: Choice of course of action.

After consulting with a subject-matter expert and the client, the therapist with the client identifies that alternative 3 best complies with the needs of integrity and client autonomy and dignity.

Step 7: Action, with a commitment to assume responsibility for the consequences of the action.

There is a possibility that adverse consequences will arise. Yet, Lumina recognizes that she must take responsibility for these outcomes.

Step 8: Evaluation of the results of the course of action.

The therapist will closely monitor Drew's safety and ability to provide consent. She will continue to engage the client in co-exploring this situation for the purposes of observing outcomes and increasing decisional equity.

Step 9: Assumption of responsibility for consequences of action, including correction of negative consequences, if any, or re-engaging in the decision-making process if the ethical issue is not resolved.

Developing a plan for the use of GI-referential language is necessary. If Drew wants to conceal her GI from those outside agency staff and her circle of care, the verbal use of feminine pronouns may be appropriate in private sessions. However, to mitigate outing risks, gender-neutral (e.g., they/them/theirs or 'the client') or masculine labels (e.g., he/him/his) can be used for written or public references, but this should only occur at the client's request or else it represents misgendering, which is unethical and considered a form of violence (*AB v CD and EF*, 2019; Ashley, 2019). If Drew seems unable to understand this issue, or if a serious risk of foreseeable, significant harm emerges, then Lumina may need to exercise her authority to breach confidentiality in the name of client protection (Bester et al., 2016; Child, Youth and Family Enhancement Act, 2000; CPA, 2017a, II.42).

In the case of a rupture, rebuilding the alliance will be necessary. The therapist must also seek personal counselling to address her biases towards Drew's parents, so she can provide them with dignity and respect that they deserve while lessening the potential ethical risks associated with her prejudices.

Step 10: Appropriate action to prevent future occurrences of the dilemma.

Principle IV (CPA, 2017a) calls for improving the profession (Sugarman, 2015). Advocating against these outing risks and espousing a relational, self-aware, and socially just lens may support Lumina in this mission. Several recommendations will be presented in the following section to complete this step and to help the therapist navigate these situations in the future.

## Record Keeping Recommendations for 2SLGBTQIA+ Clients

Five recommendations for charting with 2SLGBTQIA+ clients emerged as a result of the analysis of the literature and the case study. Due to the absence of empirical evidence and the authors' lack of authority over regulatory bodies, these recommendations are nonprescriptive. Nonetheless, they may facilitate alignment with the standards of the discipline and are, to the authors' knowledge, the first of their kind.

### Recommendation 1: Codevelop a Plan with the Client for GI- and SO-Referential Language Prior to Documenting This Information

With new 2SLGBTQIA+ clients, outing concerns surrounding documentation and confidentiality should be broached at the earliest opportunity (Boroughs et al., 2015) and preferably prior to documenting their GI or SO information. At the minimum, this conversation should include the following: the limits of confidentiality and record keeping as they relate to client-specific outing risks (Boroughs et al., 2015); their right to decline offering any outing information, including "their right NOT to provide GI or SO information on intake forms…; which names and pronouns to use in counselling; whether the client is out" (Gelineau-Olay, 2023, p. 64); and "with whom [they] prefer not to share [their GI]" (Perry & Green, 2017, p. 22) or SO. Psychologists may also document the client's response to the last item at the beginning of the clinical file to communicate the latter's confidentiality boundaries to other staff (Perry & Green, 2017).

Similarly, client consent should be obtained before referring them to and sharing their GI or SO with other providers (Perry & Green, 2017), as one cannot presume that they consent to disclosing this information—even to those within their circle of care—on the basis of coming out to their therapist (Canadian Public Health Association & Canadian HIV/AIDS Legal Network, 2017). This explanation also suggests that psychologists should remain cautious when faced with situations wherein they are unable to deny access to client records (e.g., communal electronic health record databases for provincial public health services).

### Recommendation 2: Document SO- or GI-Referential Information in Session Notes if and Only if Germane and Consented to

Therapists should reference the client's GI or SO in session notes only if two conditions are met: 1) these attributes are central to the latter's presenting problem and thus essential for their care (Boroughs et al., 2015), and 2) the client has consented to entering these items into their file. If these requisites are not met, then it is strongly advised to examine whether there is any need to include this information at all. Thus, when creating documents for 2SLGBTQIA+ clients, limiting the amount of personal detail recorded and using progress- or change-focussed notes (Hodson & McBride, 2022) may facilitate privacy while fulfilling their primary function of enhancing the client's treatment (CPA, 2017a; Hutchinson et al., 2008).

Achieving this aim, however, requires careful consideration of data management practices that are often overlooked or taken for granted. For instance, psychologists must identify what information implicitly or explicitly identifies GI or SO (e.g., alluding to top surgery, gender dysphoric symptoms, or using gendered pronouns for same-gender partners). They should remove these references whenever possible, not only from session notes but also when discussing the case with other professionals (e.g., during supervision or consultation). These actions respect the client's confidentiality needs, but, because they may violate expected sharing practices, the therapist may need to justify their vagueness to their colleagues. Furthermore, counsellors practicing from a psychodynamic orientation may face particular challenges in relying on progress notes alone since these records preclude the documentation of highly detailed, introspective processes (Mills, 2014).

### Recommendation 3: Utilize Affirming language as Much as Possible Where Safe and Appropriate to Do So

The use of GI and SO affirming language is considered best practice (Coleman et al., 2022; Potter, 2020), and to achieve this, it is advisable to mirror the client's vocabulary (Perry & Green, 2017)—language which should always be used when referring to clients who indicate this as their preference. This includes matching their use of culturally specific terms (e.g., '2-spirit' or 'fa'afafine' instead of 'nonbinary', 'gender fluid', etc.; Coleman et al., 2022). Furthermore, if the client's GI or SO is recorded in their file, therapists should volunteer to update these labels as often as needed to ensure that they and other staff are using affirming language (Potter, 2020).

However, with closeted clients or those concerned about the public knowledge of their GI or SO, it may be necessary to codevelop a plan for referencing these characteristics in an affirming yet confidentiality-protecting manner. For example, the counsellor and the client might decide to use exclusively affirming terms during private, verbal interactions within the alliance but language that better conceals the client's GI or SO beyond this, including in their documentation (see Recommendation 4 for some examples of GI- and SO-concealing terminology). In this case, psychologists must remain attentive to their language, as they may become accustomed to the use of affirming language when referring to the client, thereby making them susceptible to the accidental use of these outing terms in other, nonconfidential settings (e.g., session notes or consultations). This poses a particular risk if entered into the client's file due to the relative permanence and accessibility of these documents by other professionals.

### Recommendation 4: Consider Using Neutral or Unmarked Client Descriptors When Creating Session Notes

Language that is gender neutral and omits 2SLGBTQIA+-specific qualifiers may reduce points of reference to GI and SO when creating records for clients who are concerned about outing. For TGD clients, counsellors may strive to conceal their closeted GI by using terms like ‘the client’ or they/them/theirs instead of gendered pronouns. These replacements may be particularly valuable when creating records for clients who use neopronouns (e.g., ve/vir/vis), because these words act as salient demarcations of TGD identity. Furthermore, removing qualifying adjectives from demographic terms may help conceal the client’s GI or SO. Some examples of this practice include swapping ‘preferred or chosen name’, ‘queer couple’, and ‘transmasculine partner’ for ‘name’, ‘couple’, and ‘partner’, respectively. Additionally, reducing the specificity of descriptions—such as using the term ‘clothing’ instead of ‘dress’ or “social expectations” instead of “gender role expectations”—may serve a similar function.

The first practice may also validate and normalize the client’s GI or SO while preventing “verbal othering” (Gelineau-Olay, 2023, p. 67) that occurs through the use of 2SLGBTQIA+ specific demographic labels (Ashley, 2021). However, psychologists must consult with clients prior to implementing this language in their record keeping, as some individuals may prefer the use of their GI- or SO-specific labels, and adopting gender neutral language without the client’s consent represents a form of misgendering.

### Recommendation 5: Use Open Notes and Shared Decision-Making

Relational approaches to charting might also attenuate outing risks, thus indicating the value of *open notes*: a form of record keeping characterized by full transparency and collaborative authorship within the alliance (Hodson & McBride, 2022; Schwarz et al., 2023). This method allows 2SLGBTQIA+ clients the opportunity to provide the therapist with feedback on the notetaking style, thus providing a medium for the joint remediation of errors and confidentiality threats and shared decision-making in charting (Bemister & Dobson, 2011; Perry & Green, 2017).

2SLGBTQIA+ clients hold the most knowledge of their wants, needs, and experiences, and as such they appear to have the greatest capacity to make functional charting decisions protective of their subjective privacy and confidentiality needs (Perry & Green, 2017). Thus, if clients have been sufficiently informed of outing risks and consent to documenting these terms in their files, psychologists should mirror the latter’s terminology in their record keeping if safe and appropriate to do so.

It should be stated that there has been some debate regarding whether open notes contribute to ruptures in the alliance by discrediting the therapist’s competence or trustworthiness (Mills, 2014). Other authors have rejected this stance, citing benefits associated with relational approaches to record keeping (Bemister & Dobson, 2012) and shared decision- making (Nieder et al., 2020).

### Limitations

The void of research on charting practices and their influence on 2SLGBTQIA+ clients makes it very difficult to offer evidence backed recommendations. In addition, they need to be vetted by 2SLGBTQIA+ stakeholders and therapists with expertise in supporting this group. Until then, these suggestions simply provide a starting point for further investigations. Among related future literature, it is hoped that this manuscript will inspire the development of a new ethical dilemma for the next companion manual to *the Code* for the purpose of illustrating how to be more culturally sensitive to the diversity existing among subsets of the 2SLGBTQIA+ community in effectively developing methodology and interpreting findings (Cameron & Stinson, 2022; Roemer, 2023; Teo, 2009, 2010, 2015; Ward, 2017).

## Conclusion

As the legal scholar Shirin Ebadi (2006) wrote, “a single case is rarely the real battle; a case is a symptom of an injustice embedded in the law itself” (p. 211). Similarly, what makes outing a risk for psychological record keeping (Boroughs et al., 2015) is its correlation to cisheterosexist biases and norms across society. There is a considerable lack of direction in the literature regarding how to document risky GI and SO information in the absence of privilege when, in compliance with broad professional standards, this data must be recorded, and current research suggests that the degree of provider training in 2SLGBTQIA+ topics is incommensurate with that required for competence (Baiocco et al., 2022; Coleman et al., 2022; Lau et al., 2020). Despite this, therapists must fulfill their ethical obligations. It is vital psychologists ensure their note taking procedures are attentive to the diversity and experiences with social injustice found within the 2SLGBTQIA+ community to serve the ethical purposes of recordkeeping.

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## Appendix 1: Principles, Values, and Standards Implicated in the Dilemma

*Principles Contained in the Canadian Code of Ethics for Psychologists and their Corresponding Values and Standards*

| **I. Respect for the Dignity of Persons and Peoples** | **II. Responsible Caring** | **III. Integrity in Relationships** | **IV. Responsibility to Society** |
|---|---|---|---|
| General Respect (1-4) | General Caring (1-5) | Accuracy/Honesty (1-8) | Development of Knowledge (1-3) |
| General rights (5-8) | Competence and self-knowledge (6-12) | Objectivity/lack of bias (9-12) | Beneficial activities (4-14) |
| Non-discrimination (9-11) | Risk/benefit analysis (13-17) | Straightforwardness/ openness (13-22) | Respect for society (15-18) |
| Fair treatment/due process (12-15) | Maximize benefit (18-27) | Avoidance of incomplete disclosure and deception (23-27) | Development of society (19-28) |
| Informed consent (16-26) | Minimize harm (28-39) | Avoidance of conflict of interest (28-32) | |
| Freedom of consent (27-30) | Offset/correct harm (40-47) | Reliance on the discipline (33-35) | |
| Protections for vulnerable individuals and groups (31-36) | Care of animals (48-54) | Extended responsibility (36-37) | |
| Privacy (37-42) | Extended responsibility (55- 56) | | |
| Confidentiality (43- 45) | | | |
| Extended responsibility (46- 47) | | | |

## APPENDIX 2: INSTRUCTIONS FOR AUTHORS FROM CANADIAN PSYCHOLOGY / PSYCHOLOGIE CANADIENNE

The manuscript presented in Appendix 1 was created in compliance with the authorship instructions for a special issue of Canadian Psychology /Psychologie canadienne, the journal to which this author intends to submit for publication. This section identifies general author guidelines for submission to this journal. Because there are unique procedural guidelines for submitting to this special issue, these will also be provided in the final section.

### General Author Guidelines

Authors are required to adhere to specific parameters when preparing for submission. These have been replicated from the source below:

Canadian Psychological Association. (2023). *Canadian Psychology / Psychologie canadienne*. American Psychological Association. https://www.apa.org/pubs/journals/cap

#### *Journal Scope Statement*

This journal is a publication of the Canadian Psychological Association. Canadian Psychology / Psychologie canadienne publishes generalist articles in areas of theory, research, practice, education, and policy that are of interest to a broad cross-section of psychologists. The journal publishes systematic reviews (including meta-analyses) and literature reviews relevant to theory or research in basic and applied areas—for example, human and non-human neurosciences, cognitive, perception, history and theoretical systems, quantitative, developmental, social, personality, clinical, counselling, educational and school, industrial/organizational, community, as well as teaching and learning.

#### *Submission*

Prepare manuscripts according to the Publication Manual of the American Psychological Association using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the Publication Manual). APA Style and Grammar Guidelines for the 7th edition are available.

#### *Masked Review Policy*

All submissions undergo an anonymous review. If an author does not want a masked review, this should be indicated in the cover letter along with a brief explanation. Instead of indicating authors' names and affiliations on the title page, authors should place this information in the cover letter, which is not seen by reviewers.

All identifying information should be removed from the manuscript. Authors should make every effort to see that the manuscript itself contains no clues to their identities. If your manuscript was mask reviewed, please ensure that the final version for production includes a byline and full author note for typesetting.

Canadian Psychology considers all manuscripts on the strict condition that they have been submitted only to Canadian Psychology, that they have not been published already, and that they are not under consideration for publication or in press elsewhere.

### *Manuscript Language*

Manuscripts may be submitted in French or in English.

### *Manuscript Preparation*

Prepare manuscripts according to the Publication Manual of the American Psychological Association using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the Publication Manual). Review APA's Journal Manuscript Preparation Guidelines before submitting your article. Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the Manual. Additional guidance on APA Style is available on APA Style website.

### *Tables*

Use Word's insert table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

### *Abstract and Keywords*

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

### *Public Significance Statements*

Authors submitting manuscripts to Canadian Psychology are required to provide 2–3 brief sentences regarding the public significance of the study or meta-analysis described in their paper. This description should be included within the manuscript on the abstract/keywords page. It should be written in language that is easily understood by both professionals and members of the lay public. When an accepted paper is published, these sentences will be boxed beneath the abstract for easy accessibility. All such descriptions will also be published as part of the Table of Contents, as well as on the journal’s web page.

To be maximally useful, these statements of public significance should not simply be sentences lifted directly from the manuscript. They are meant to be informative and useful to any reader. They should provide a bottom-line, take-home message that is accurate and easily understood. In addition, they should be able to be translated into media-appropriate statements for use in press releases and on social media.

Prior to final acceptance and publication, all public significance statements will be carefully reviewed to make sure they meet these standards. Authors will be expected to revise statements as necessary.

### *References*

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the references section.

### *Permissions*

Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments).

### *Publication Policies*

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications. Authors may post the final accepted, preformatted version of their article—the accepted manuscript—on their personal websites, university and preprint repositories and author networking sites. If your article is accepted for publication, the posted manuscript must include a note linking to the final published article.

If your manuscript has been posted to a preprint archive, include a link to the preprint in the cover letter and in the author note. Note that any press coverage of prepublication manuscripts may preclude press releases by APA's Public Affairs Office. See also APA Journals® Internet Posting Guidelines.

Authors must disclose any prior uses of data reported in the manuscript in the author note and in the cover letter, which should include a complete reference list of these articles as well as a description of the extent and nature of any overlap between the present submission and the previous work.

Authors must disclose all sources of financial support for the conduct of the research (e.g., "This research was supported by NIDA grant X"). If the funding source was involved in any other aspects of the research (e.g., study design, analysis, interpretation, writing), then clearly state the role. If the funding source had no other involvement other than financial support, then simply state that the funding source had no other role other than financial support. Also provide a conflict-of-interest statement disclosing any real or potential conflict(s) of interest, including financial, personal, or other relationships with other organizations or companies that may inappropriately impact or influence the research and interpretation of the findings. If there are no conflicts of interest, this should be clearly stated.

## Guidelines for Submitting to the Special Issue

There are also submission requirements for that are unique to the special issue. Thus, its specific author guidelines have been reproduced from the source below:

Canadian Psychology. (2023, October). *Call for papers: 40th anniversary of the Canadian Code of Ethics for Psychologists*. American Psychological Association. https://www.apa.org/pubs/journals/cap/40-anniversary-canadian-code-ethics-psychologists

### *Background*

The idea of a special issue of Canadian Psychology / Psychologie canadienne (CP/PC) honouring both the legacy and the enduring value of the Code to psychologists in Canada and around the world was first advanced by the Canadian Psychological Association Committee on Ethics. The special issue will provide an opportunity to engage in reflection and analysis of the ethical challenges facing psychology and how our Code serves to embody our values as a discipline and advance our understanding of how to meet our ethical obligations to society. Its message will be one of inspiration. The special issue will be of relevance to Canadian psychologists, students, and supervisees, as well as members of cognate disciplines and consumers of psychological services.

### *Types of Submissions*

Submissions may include systematic or literature reviews, conceptual/theoretical perspectives or discussions, and practical applications or extensions of the Code. Relevant content article writing topics include, but are not limited to, ethical pedagogy, working with underserved populations, reconciliation and social justice, international perspectives on the Code, as well as current and emerging ethical issues related to things such as technological advancements (e.g., information and communication technology, artificial intelligence), medical assistance in dying, and moral injury. Submissions may pertain directly to one or more aspects of the Code and/or any of its associated specialty guidelines, including potential new applications or extensions of the Code.

### *Timeline and Submission Details*

Step 1: Letter of intent

1. Authors interested in submitting a manuscript for the special issue are required to submit a Letter of Intent (LOI) to the coguest editors before preparing their manuscript. They should ensure that the subject line in their email to the coguest editors reads CP/PC 40th Anniversary of Canadian Code Special Issue.

2. The LOI should be no more than 1 page in length and should list tentative co-authors and summarize the main questions/purpose of the paper and the key topic(s) to be discussed. The relevance of the proposed topic(s) to the special issue theme (i.e., the Canadian Code of Ethics for Psychology) should also be discussed.

3. Each LOI will be reviewed to assess suitability/fit with the Special Issue and CP/PC's mission/objectives.

4. Invitations to submit a full manuscript will be extended only to authors whose LOI has been approved. These invitations will not guarantee acceptance of the work.

5. The deadline for submission of LOIs is February 1, 2024.

Step 2: Manuscript submission

- Manuscripts may be submitted in French or in English.

- Manuscripts should be prepared according to the journal's formatting instructions and the 7th edition of the Publication Manual of the American Psychological Association, and submitted through the Canadian Psychology / Psychologie canadienne submission portal.

- Authors are encouraged to explicitly provide rationale within their article as to why the paper is relevant to the Code.

- All submitted manuscripts will undergo peer review prior to a final decision on publication. Manuscripts that are deemed inappropriate for inclusion in this special issue may be rerouted (with the authors' knowledge and consent) for consideration for publication in CP/PC as regular papers.

- Manuscripts accepted for publication will not appear online before being included in a printed Special Issue planned for publication in 2026.

- The deadline for manuscript submission is August 31, 2024.

General author guidelines for authors have also been by the journal. If the manuscript has been posted to a preprint archive, include a link to the preprint. Authors of accepted manuscripts are required to transfer the copyright to CPA.

### *Ethical Principles*

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13). In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication. Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.